FINAL REPORT OF THE ALAMEDA COUNTY MEDICAL CENTER TASK FORCE

TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS

APRIL 2, 1996

Supervisor Wilma Chan, Chair
David Kears, Director, HCSA
Authored By:
Dorothy Graham
Susan Rosenthal

AGENDA _____ April 2, 1996

BOARD OF SUPERVISORS

WILMA CHAN
SUPERVISOR THIRD DISTRICT

March 26, 1996

Other Members of the Board of Supervisors
Administration Building
1221 Oak Street
Oakland, Ca. 94612

Dear Board Members:

SUBJECT: Alameda County Medical Center Task Force - Final Report

RECOMMENDATIONS:

In order to proceed with the implementation of system improvements outlined in the ***Alameda County Medical Center Task Force - Final Report***, it is recommended that the Board approve the following:

1. Receive and accept the attached ***Alameda County Medical Center Task Force Final Report, April 2***, 1996.

2. Adopt the seventeen recommendations outlined in the Executive Summary.

3. Direct the Alameda County Medical Center Chief Executive Officer to proceed with the development of an implementation plan that includes a detailed cost analysis, specific timelines, and measurable benchmarks by which progress and success can be monitored.

4. Authorize the Alameda County Medical Center Chief Executive Officer to proceed with the creation of the Strategic Planning Committee. This committee will, among other things, implement the recommendations noted in item two above and provide quarterly progress reports to the Board.

SUMMARY:

In August of 1995, the Board created the Task Force on the future of the Alameda County Medical Center (ACMC). The purpose of the Task Force was to create an objective, rational process for making some basic decisions regarding the future direction of the Medical Center. I would like to formally extend my appreciation to each and every individual involved in the work of the Task Force. During the last six months the Task Force, community observers, consultants and experts, Health Care Services Agency staff, and staff from my office have worked diligently to form the consensus reflected in the ***Alameda County Medical Center Task Force Final Report, April 2***, 1996. In summary, the Task Force concluded that the Medical Center can and should continue to play an important role as a competitive, comprehensive provider of quality health services for the residents of Alameda County.

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DISCUSSION AND FINDINGS:

The Task Force held its first meeting on September 20, 1995. There was uncertainty and upheaval at the Medical Center and there was little confidence that the Medical Center was ready for managed care or could survive into the future. During the next six months the Task Force studied, discussed and deliberated on the following reports and panel discussions:

1. Demographics and utilization of the Medical Center
2. Financial Information
3. Local Competitive Factors and national trends
4. Governance
5. Implications of Managed Care Panel
6. *Status Report on California's Other County Hospitals*
7. *Evaluation of Options for the Future of the Alameda County Medical Center* by Consultant Henry Zaretsky, Ph.D.

Upon the conclusion of its work on March 21, 1996, the Task Force had reached consensus on the future direction of the Medical Center and steps were identified to begin to realize the future.

The Task Force closed its last meeting with a strong belief that the Medical Center can and should continue to play an important role as a competitive, comprehensive provider of quality health services for the residents of Alameda County. The Task Force recognized that there are many risks and financial commitments involved in any course we choose. They also acknowledged that the attached recommendations require a renewed sense of commitment and willingness to set aside entrenched patterns and biases.

Your Board is now asked to direct staff to proceed with the development of an implementation plan that includes a detailed cost analysis, specific timelines, and measurable benchmarks by which progress and success can be monitored. Although these recommendations now require specific action by the Alameda County Medical Center and its Strategic Planning Committee, many will eventually come to the Board of Supervisors or the new governing body for action, either for appropriations or policy direction.

FINANCIAL IMPACT:

There is no financial impact at this time.

Sincerely,

Wilma Chan

Wilma Chan, Supervisor
Second District

Attachment
cc: County Administrator
County Counsel
HCSA Director

ACKNOWLEDGMENTS

As chair of the Alameda Medical Center Task Force, I would like to acknowledge the many people who participated in the deliberations and proceedings which culminated in the development of the ***Alameda County Medical Center Task Force, Final Report, April 2, 1996.***

First and foremost I would like to acknowledge the other members of the Board of Supervisors, Edward Campbell, Keith Carson, Mary King, and Gail Steele for their foresight in establishing this Task Force. I would especially like to thank Supervisor King for soliciting and incorporation input from the Task Force on the governance recommendations; Supervisor Steele for her frequent attendance and participation in Task Force proceedings; and Supervisor Carson for Amalia Egri's participation in all Task Force proceedings.

Appreciation is hereby expressed for each member of the Task Force as follows (listed alphabetically): Erma Albert, RN; Judy Armstrong; Harold Brazil, MD; Robert Cooper, MD; Jim Devitt; Ron Eisenberg, MD; Hussam El-Gohary, MD; Rob Feldman, MD; Peter Forster, MD; Al Groh; Dellreitta Guion; Jay Harness, MD; Doug Hickling; Arlen Hoh, MD; Sandra Holliday; Fran Jefferson; Jacqueline Jones; Dave Kears; Veda La Baer; Margaret Leong; Charlotte Martinelli; Pamela Martinez; Betty Moose; John Norton, MD; Carol Oakley; Claude Organ, MD; Arnold Perkins; Ted Rose, MD; Kathy Schnepple; Ruth Shane; Ralph Silber; Michael Smart; Joni Thomas; Marye Thomas, MD; Jonas Williams, MD; and Gary Young, MD.

The work of the Task Force was supported by a Technical Support Committee and a team of facilitators and consultants. The technical support was provided by: Yolanda Baldovinos; Vana Chavez; Natalie Curson; Dorothy Graham; Jason Lauren; Charlotte Martinelli; Carol Oakley; and Susan Rosenthal. Facilitation and consultation was provided by The Center for the Common Good including: Martin Paley; Gordon Firestein; Nancy Lee; Marty Boyer; and Liston Witherill. Additional consultation was provided by Henry Zaretsky, Ph.D., Henry Zaretsky and Associates.

Gratitude is also express to a number of outside presenters who helped to inform the process, included among those are: Nina Maruyama, Alameda Alliance for Health; Barbara Kempzcinska, Blue Cross; Jean Nudelman, Kaiser Health System; and Barbara Ramsey, MD, Native American Health Center.

Last but not least, a special thank you to Linda Arellano, Sarah Linder, and Joanne Parenti for their support.

Supervisor Wilma Chan, Chair
Alameda County Medical Medical Center Task Force

ALAMEDA COUNTY MEDICAL CENTER TASK FORCE -

FINAL REPORT

TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS - APRIL 2, 1996

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EXECUTIVE SUMMARY

INTRODUCTION

In August of 1995, Supervisor Wilma Chan and the Board of Supervisors created a Task Force on the Future of the Alameda County Medical Center (ACMC). The Task Force's creation came at a time of uncertainty and upheaval at the Medical Center. There was little confidence that the institution was ready for managed care or could survive into the future. At the same time, the Medical Center has experienced significant cuts to its budget, necessitating cuts in services, programs, staffing, and infrastructure.

Supervisor Chan and the Board of Supervisors called for the formation of a broad based task force in order to begin an orderly process to examine the mission, operations and competitive position of the Medical Center *(defined as the system of care including Highland Hospital, Fairmont Hospital, John George Psychiatric Pavilion and county operated ambulatory care clinics)*. There was also a need to set the framework for an ongoing strategic planning process.

The Task Force grew out of a commitment to find the proper role for the Medical Center and to preserve health care services to the indigent and working poor. Funding has declined and will continue to decline further. Competition is fierce for any insured patients. On top of the difficult situation in health care, the County's general fiscal situation is not robust. The Board of Supervisors is not in a position to make up the loss of State and Federal dollars with general fund money.

All counties in California with hospitals have had to grapple with the issue of whether to continue to be a direct provider of care. There are basically three choices:

1. Continue to provide most services directly and be a competitive, viable acute care hospital.
2. Merge with or sell to another private hospital organization.
3. Close and contract out for services.

With the changing marketplace and fiscal pressures, it is imperative that Alameda County define a clear direction for the Medical Center. **The time has come to make a choice.**

The purpose of the Task Force was to create an objective, rational process for making some basic decisions regarding the future direction of the Medical Center. The charge to the Task Force was to recommend the proper role for the Medical Center in fulfilling the County's responsibility and mission. Through an open process a plan was created that would guide the Medical Center in planning for the future. The plan would also assist the Board of Supervisors in making strategic and budgetary decisions that would ensure the continued provision of services to the indigent population.

The Task Force membership was broad, representing the entire Medical Center community. It included consumers, unions, medical staff, community based organizations, Medical Center administration, political leadership and other Health Care Services Agency leadership. The Task Force held its first meeting on September 20, 1995 and concluded its work on March 21, 1996.

Although the membership of the Task Force was diverse, there was a commitment to an open, objective and responsible process. The Task Force usually broke up into small groups for more intensive discussion of the issues. During the course of the deliberations there was a growing sense of a shared commitment and fate among the members. That spirit is reflected in the final recommendations.

During the course of the deliberations, the Task Force studied, discussed and deliberated on the following reports and panel discussions:

1. Demographics and utilization of the Medical Center
2. Financial Information
3. Local Competitive Factors and national trends
4. Governance
5. Implications of Managed Care Panel
6. *Status Report on California's Other County Hospitals*
7. *Evaluation of Options for the Future of the Alameda County Medical Center* by consultant Henry Zaretsky, Ph.D.

By the end of the deliberations a consensus was reached on the future direction of the Medical Center and steps were identified to begin to realize that future.

FINDINGS

The recommendations in the following section are based on a series of findings made by the Task Force. These findings are a result of analyzing and synthesizing the various reports, panels, small group and large group discussions. The most important findings are summarized in this section.

1. DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM

A major source of funding for indigent care is the Disproportionate Share Hospital (DSH) program, which is currently based on the hospitals' volume of Medi-Cal inpatient utilization. In the current fiscal year, $30 million in DSH funding has supported the Medical Center. For FY 96-97, $15-20 million is projected. Highland's Medi-Cal patient days need to be preserved through a combination of enrolling a sufficient number of adults and children through both the Local Initiative (Alliance) and commercial plan (Blue Cross) at ACMC primary care sites, and through referrals for inpatient care from other network providers. In recent years, the Medical Center has had a market share of 23% of all Medi-Cal patient days in Alameda County in the AFDC-related aid categories. In order to maintain the AFDC managed care Medi-Cal days there must be at least 13,400 adult enrollees assigned to the Medical Center system (including all referral sources).

2. CAPITAL FUNDING THROUGH SB 1732

Alameda County still has an opportunity to take advantage of State funding to assist with a major rebuilding project for the Alameda County Medical Center. Alameda County filed architectural plans with the state in time to qualify for SB 1732 (the Construction/Renovation Reimbursement Program) financial assistance. The State Medi-Cal program will pay a share of the annual debt service based on the hospital's percentage of Medi-Cal days. In Alameda County that is approximately 54%. The Agency is currently discussing modifications of its SB 1732 application for greater flexibility in its project design for inpatient and outpatient use.

3. COMPETITIVENESS

The Medical Center can change and become a competitive institution in today's health care marketplace. The Medical Center must be marketable and compete for patients through a combination of its cost effectiveness, facilities, amenities, quality, customer service, specialized medical services, teaching program, and unique support services.

4. PRIVATE SECTOR COOPERATION

It is in the interest of the private hospitals to assist the ACMC in retaining its Medi-Cal market share so that both sectors will remain financially healthy. Private providers have not wanted to treat this population and will incur major losses from treating them. The Medical Center's ability to maintain its emergency department and to be a provider of last resort is contingent on its ability to maintain its Medi-Cal patient base.

5. LOCAL MEDICAL MARKETPLACE

Managed care discourages inpatient utilization. Private hospitals in the area have many empty beds and are now actively competing for Medi-Cal patients - especially OB. This has made it difficult to maintain the patient days necessary to claim all DSH money.

Alameda County hospitals are also rapidly forming into networks hoping to negotiate jointly for managed care contracts, as well as to link hospitals and physicians into an integrated delivery system. This trend may be linked directly to hospitals' long term survival, in that insurers have shown a preference for contracting with networks as opposed to single hospitals.

6. CALIFORNIA'S OTHER COUNTY HOSPITALS AND HEALTH SYSTEMS

Alameda County is not alone in facing the issues and dilemmas regarding the provision of health care services to its indigent population. Counties have generally responded to the changing environment in one of two ways. Most have made a renewed commitment to maintain their hospitals and adapt them to the current challenges. A second group has decided to sell, lease or merge their facilities and abandon their role as direct providers of inpatient care. Counties that decided to remain open have adopted a range of strategies, including:

- Most counties have embarked on fairly extensive rebuilding and renovation project, using SB 1732 funds or internal savings. Others have made extensive cosmetic improvements.
- Many have started new services and made operational improvements to manage their patients and resources more efficiently to establish a more competitive position.
- County hospitals are changing to meet the needs of other primary care providers in the community in order to retain voluntary admissions.
- Several counties are providing incentives to their employees to utilize county services
- Counties are consciously utilizing their Local Initiative (Medi-Cal managed care plan) to strengthen safety net and county run services.

7. THE CHOICES WE FACED

Four alternative models for the future of the Medical Center were evaluated by Consultant Henry Zaretsky, Ph.D.:

1. "Treat and transfer' facility, where the Highland campus would restrict its inpatient services to trauma and emergency patients.

2. "Treat and transfer" and indigent facility where Highland would also treat the county indigent patients.

3. Full service competitive hospital, retaining its role as trauma center, indigent provider and a major Medi-Cal and all other payor provider.

4. Close as an inpatient provider and contract with private hospitals to meet Section 17000 obligations.

Given existing payment mechanisms, where a major portion of state and federal funds used to subsidize county-indigent patients is derived through the Medi-Cal program in the form of disproportionate share payments, the only feasible alternative is for the Medical Center to continue to be a high-volume Medi-Cal provider. Given the movement to Medi-Cal managed care and competitive pressures in general, the Medical Center must take initiatives - capital investments and programmatic changes - to be a competitive hospital. Failure to do so would result in Alameda County being unable to support its Section 17000 obligation without substantial general fund expenditures, either directly through operating its own hospital, or indirectly, through private sector contracting.

RECOMMENDATIONS

The Task Force has concluded that the Medical Center can and should continue to play an important role as a competitive, comprehensive provider of quality health services for the residents of Alameda County. After examining many options, as well as the obstacles we face, the Task Force recognizes there are many risks and financial commitments involved in any

course we choose. These recommendations also require a renewed sense of commitment and willingness to set aside entrenched patterns and biases. Yet we believe there exists no other viable option if we are to fulfill the legal requirement and community need of providing health care for those who depend upon the County.

The Task Force requests that the Board of Supervisors adopt these recommendations and direct the Alameda County Medical Center and its Strategic Planning Committee to implement these recommendations and provide quarterly progress reports to the Board.

We ask that your Board direct staff to proceed with the development of an implementation plan that includes a detailed cost analysis, specific timelines, and measurable benchmarks by which progress and success can be monitored. Although these recommendations now require specific action by the Alameda County Medical Center and its Strategic Planning Committee, many will eventually come to the Board of Supervisors or the new governing body for action, either for appropriations or policy direction.

Policy Recommendations

1. **Adopt and affirm the future role of all campuses of the Alameda County Medical Center as a competitive, integrated health care system serving all payors (indigent, Medi-Cal, Medicare and private pay). Endorse the role of the Highland Campus as a competitive acute general hospital serving all payors, within that system.**

2. **The Medical Center must define financial (budgetary) and operational benchmarks to be reached with specific timelines, concurrent with development of capital improvement plans.**

3. **Develop policy recommendations to the Board of Supervisors, the Medical Center, and Alliance Board that will strengthen the role of the Medical Center as an Alliance provider.**

4. **Establish policy and financial incentives that will encourage the county clinics and community based clinics to use the Medical Center as the first choice for hospital and medical specialty referrals. Appropriate staff representing the Medical Center, community based organizations and other community physicians should be brought together to identify and implement the improvements needed to facilitate expanding the referral base.**

5. **Develop and implement incentive plans for encouraging county employees to use the Medical Center and its affiliated clinics.**

6. **Enlist the support of area hospitals to protect the Medi-Cal patient base and to coordinate programs.**

Recommendations for Capital Improvements

7. Conduct a feasibility study on reactivating Alameda County's application for SB 1732 money for major rebuilding project at the Highland campus. Report back to the Board of Supervisors by May 15, 1996. If financial assistance from SB 1732 funds is not feasible, an alternative capital improvement plan should be developed.

8. Develop and implement a plan, including financial strategies, for immediate cosmetic improvements and renovations.

9. Reorganize the physical layout of outpatient facilities at the Highland campus to be patient friendly.

10. Develop and implement a capital plan for the modernization of medical equipment.

Programmatic and Operational Recommendations

11. Change the culture of the entire institution by implementing customer service strategies which address patient needs and acknowledge that clients have choices.

12. Accelerate the acquisition and implementation of a modern management information system.

13. Create systems that allow for easy access for all providers and patients to specialty clinics and inpatient services.

14. Make the clinic appointment and registration system easily accessible to patients and providers. Develop better communication between community and specialty care providers.

15. Explore development of formal affiliations, networks and innovative physician arrangements on behalf of the Alameda County Medical Center with area HMO's, medical centers and physician groups.

16. Develop a marketing plan for Alameda County Medical Center for managed care patients.

17. Develop a plan for fundraising from internal and external sources.

NEXT STEPS - WHERE DO WE GO FROM HERE?

A transition is taking place to an ongoing strategic planning process for the Alameda County Medical Center. A Strategic Planning Committee of thirteen members has been created by CEO Mike Smart. The first charge to the Strategic Planning Committee is to oversee the implementation of the tasks identified by the Task Force, to develop a strategic plan, and to oversee the development of a revised plan for the County's SB 1732 capital project. It will report to the Board of Trustees on a quarterly basis.

Steps have already been undertaken to implement the Task Force's recommended operational improvements. A consolidated work plan has been developed with responsible persons identified and target dates set, combining the tasks from the Task Force work session with Dr. Zaretsky's recommended implementation plan. Tasks associated with accommodating managed care patients assigned to the Medical Center have begun to be implemented through a point of service program. A meeting has taken place between the Health Care Services Agency and the State Department of Health regarding the reactivation and modification of Alameda County's SB 1732 proposal.

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The Task Force is pleased to forward this report the Alameda County Board of Supervisors. The Task Force has played an invaluable role in bringing diverse interests together to decide upon and commit to a shared vision on the future role of the Alameda County Medical Center. It is crucial that this not be a report that is simply filed and ignored. The time is short, and if we are not successful, the health of our community is at risk. By approving its recommendations, the Board of Supervisors can take the next step in making that vision a reality. Each and every member stands ready to assist in its implementation.

ALAMEDA COUNTY MEDICAL CENTER TASK FORCE

FINAL REPORT

INTRODUCTION

In August of 1995, Supervisor Wilma Chan and the Board of Supervisors created a Task Force on the Future of the Alameda County Medical Center (ACMC). The Task Force's creation came at a time of uncertainty and upheaval at the Medical Center. The Grand Jury and the Peat Marwick Consulting firm had issued reports critical of the Medical Center's long-standing fiscal and operational practices. The long time CEO of the Center had left followed by a short-lived interim leadership team. There was little confidence that the institution was ready for managed care or could survive into the future.

At the same time, the Medical Center has experienced significant cuts to its budget necessitating cuts in services, programs, staffing, and infrastructure. In the past four fiscal years, (FY 92/93-95/96) the Medical Center's[1] maintenance of effort budget was reduced by $65.5 million, including a reduction in net county cost of $21 million in the same time period. A $15 million deficit in the current operating year budget was discovered only weeks into the new budget year.

Supervisor Chan and the Board of Supervisors called for the formation of a broad based task force in order to begin an orderly process that would look at the mission, operations and competitive position of the Medical Center. *(defined as the system of care including Highland Hospital, Fairmont Hospital, John George Psychiatric Pavilion and county operated ambulatory care clinics.)* There was also a need to set the framework for an ongoing strategic planning process. Cuts were made to the 1995-96 Medical Center budget utilizing only short-term strategies. A decision by the Board on the future of the County system of care needed to be made so that future budget deliberations would fall within the context of a cost-effective and rational plan for the county for fulfilling the County's Section 17000 obligations as provider of care to the indigent.

The Task Force grew out of a commitment to find the proper role for the Medical Center and to preserve health care services to the indigent and working poor. There is general acknowledgment that there are pressures making it difficult to continue to deliver health care in the way the County always has done it. Funding has declined and will continue to decline further. Competition is fierce for any insured patients - even the Medi-Cal patients that were undesirable a few short years ago. There is an excess of acute care beds and a consolidation in the medical marketplace. Managed care puts a premium on outpatient care in an integrated system of care and squeezes out inpatient utilization. On top of the difficult situation in health care, the County's general fiscal situation is not robust. The annual net loss due to the property tax shift by the State is $80 million (about equal to the annual deficit). Therefore the Board of

[1] Includes Departments 410,(District Services) 451, (Criminal Justice -Medical) 470, (Highland) 471,(Fairmont) 473 (John George Psychiatric Pavilion)

Supervisors is not in a position to make up the loss of State and Federal dollars with general fund money.

All counties in California with hospitals have had to grapple with the issue of whether to continue to be a direct provider of care. There are basically three choices:

1. Continue to provide most services directly and be a competitive, viable medical surgical hospital.
2. Merge with or sell to another private hospital organization.
3. Close and contract out for services.

Alameda County has a long-standing commitment to providing a high degree of services to its indigent population. With the many contradictory pressures on the health care system, there is a need to find a way to assure that services are delivered in an effective and efficient manner. With the changing marketplace, Alameda County can no longer afford to drift without direction. **The time has come to make a choice.**

The Task Force has been charged with advising the Board of Supervisors on the role and responsibility of the Medical Center. Beginning with the State mandate of the Welfare and Institutions Code Section 17000 and Alameda County's own policy for assuring the health care of its medically indigent residents, the Task Force was charged with recommending the proper role for the Medical Center in fulfilling the County's responsibility and mission. Through an open process that included all interest groups of the Medical Center community the hope was that a plan would emerge that could guide the Medical Center in planning for the future. The plan would also assist the Board of Supervisors in making strategic and budgetary decisions that would ensure the continued provision of services to the indigent population.

The Task Force also heard reports and provided input on the concurrent process taking place to evaluate governance options for the Medical Center. While there was not a clear consensus on a preferred governance model at the Task Force, there was general agreement that the status quo was unacceptable and that a change is required. There was consensus that a competent group of health care experts is needed who would devote themselves to issues concerning the Medical Center.

The following is a report on the process, findings, conclusions and recommendations of the Alameda County Medical Center Task Force. The expectation and hope is that this report will form the framework for an on-going strategic planning process that will allow the Medical Center to transform itself so that it can compete, remain viable and fulfill its mission. All participants learned a lot during the process and are eager to continue to work together in order to follow through on the recommendations.

RECOMMENDATIONS

At its February 26th meeting, the Task Force heard a report from its consultant, Dr. Henry Zaretsky , Evaluation of Options for the Future of the Alameda County Medical Center, and unanimously voted to endorse that report. The report and the pursuant discussion, in combination with the other work of the Task Force, forms the basis for the final Task Force recommendations. On March 21st, the Task Force unanimously voted to support the following set of recommendations to be presented to the Board of Supervisors on April 2, 1996.

We are placing the recommendations at the very start of this report to emphasize that this is a report designed to lead to action. The recommendations are very broad and will need to be fully developed through implementation plans in the next few months. The Task Force recognizes that its conclusions and the resulting recommendations will require a renewed sense of commitment and willingness to set aside entrenched patterns and biases. Furthermore, the Medical Center must prioritize addressing the most immediate problem: to get control of the budget deficit for the coming fiscal year.

While the Medical Center needs to live within its means, there also must be a recognition by the Board of Supervisors that there is a point below which the Medical Center cannot go and still remain a viable institution. Last year, the Medical Center absorbed a disproportionate percentage of the county budget deficit. Also, over the past five years, the Medical Center has offset shortfalls in other departments. Already faced with a deficit of $25-$30 million it must absorb internally, it would not be realistic nor prudent for the Medical Center to be asked to offset any further shortfalls to the County General Fund.

The Task Force has concluded that the Medical Center can and should continue to play an important role as a competitive, comprehensive provider of quality health services for the residents of Alameda County. After examining many options, as well as the obstacles we face to survive and improve, the Task Force recognizes there are many risks and financial commitments involved in any course we choose. Yet we believe there exists no other viable option if we are to fulfill the legal requirement and community need of providing health care for those who depend upon the County.

A major source of funding for indigent care is the Disproportionate Share Hospital (DSH) program, which is currently based on the hospitals' volume of Medi-Cal inpatient utilization. In the current fiscal year, $30 million in DSH funding has supported the medical center. For FY 96-97, $15-20 million is projected. In order to maintain these funds under managed care, we need to continue to provide substantial inpatient care to the AFDC Medi-Cal population, (6,000 AFDC days in 1995) which can only come if enrollees are part of the ACMC referral base. Highland's Medi-Cal patient days would need to be preserved through a combination of enrolling a sufficient number of adults through both the Local Initiative and commercial plan at ACMC primary care sites, and through referrals for inpatient care from other network providers.

The Task Force believes that working together, the Medical Center can change and become a competitive institution in today's health care marketplace. All stakeholders including the unions, MD's employees, and volunteers affirm their unity of purpose in providing health care services to the residents of Alameda County through the Medical Center.

The Medical Center must be marketable and compete for patients through a combination of its cost effectiveness, facilities, amenities, quality, customer service, specialized medical services, teaching program, and unique support services (e.g., translation, social services).

But there is a need for some assistance. Alameda County may still be eligible to participate in the Medicaid Demonstration Section 1115 Waiver Project for Los Angeles County. The Medical Center will also need some resources directly from the County. The Task Force offers the following recommendations in three major areas: policy directives, capital improvements, and operational and programmatic changes.

The Task Force requests that the Board of Supervisors adopt these recommendations and direct the Alameda County Medical Center and its Strategic Planning Committee to implement these recommendations and provide quarterly progress reports to the Board.

We ask that your Board direct staff to proceed with the development of an implementation plan that should include a detailed cost analysis, specific timelines, and measurable benchmarks by which progress and success can be monitored. Although these recommendations now require specific action by the Alameda County Medical Center and its Strategic Planning Committee, many will eventually come to the Board of Supervisors for action, either for appropriations or policy direction.

Policy Recommendations

1. Adopt and affirm the future role of all campuses and clinics of the Alameda County Medical Center, as a competitive, integrated health care system serving all payors (indigent, Medi-Cal, Medicare and private pay). Endorse the role of the Highland Campus as a competitive acute general hospital serving all payors, within that system.

The Alameda County Medical Center Task Force unanimously endorsed this recommendation. The Task Force studied a variety of other alternatives for providing medical care to the indigent residents of Alameda County. This plan involves some risk and will require many changes in a short period of time. However, the Task Force concluded that there is no other practical and financially responsible way to meet the County's mission of providing medical care to the indigent and working poor residents in the foreseeable future.

2. The Medical Center must define financial (budgetary) and operational benchmarks to be reached with specific timelines, concurrent with development of capital improvement plans.

The Board of Supervisors, County staff, and the general public are skeptical of the ability of the Medical Center to make the operational changes necessary to become a competitive institution, especially in light of looming state and federal funding losses. The Medical Center should set appropriate benchmarks for operational improvements, to be objectively defined. These benchmarks can be monitored via status reports at Board of Trustee meetings, concurrent with progress towards implementing the capital improvement plans in recommendations 7-10 below. Examples of appropriate operational benchmarks are being able to take care of the first group of Alliance enrollees and reducing waiting times for clinic appointments to comply with managed care standards. The critical financial benchmark will be the Medical Center's ability to resolve

the FY 96-97 budget deficit, through steps which include expenditure reductions. The Strategic Planning Committee should also incorporate the immediate implementation steps recommended by Dr. Henry Zaretsky's report to deal with the Medical Center's most urgent needs to enhance its competitive position.

3. Develop policy recommendations to the Board of Supervisors, the Medical Center, and Alliance Board that will strengthen the role of the Medical Center as an Alliance provider.

Alameda Alliance for Health policies should help the Medical Center retain its Medi-Cal market share . An example of these policies is to default clients who do not choose a provider, wherever possible and practical, into the Medical Center network. Current default patterns from the first several months of Alliance operations should be reviewed as a basis for future policy recommendations. Other policy examples would be to give the Medical Center the right of first refusal to provide new required services, and to work with the Alliance to target special populations for assignment to the Medical Center network. In order to serve and manage these clients, the Medical Center must change its operations to accommodate their needs.

4. Establish policy and financial incentives that will encourage the County clinics and community-based clinics to use the Medical Center as the first choice for hospital and medical specialty referrals. Appropriate staff representing the Medical Center, community based organizations and other community physicians should be brought together to identify and implement the improvements needed to facilitate expanding the referral base.

The natural source of referrals of Medi-Cal patients to the Medical Center and its specialty clinics are the community based clinics, county operated clinics and the traditional private Medi-Cal providers in the community. For such coordination to work in the patient's best interest, the Medical Center's programs must be able to accommodate the referring clinics through timely appointment scheduling, appropriate communication and direct hospital admissions. As the Medical Center becomes better able to accommodate these needs, the Board of Supervisors should review its existing funding policy to create additional financial incentives for the geographically accessible clinics to utilize the ACMC. Due to the threat to the Highland OB Service from declining census, the most pressing policy change is for the Medical Center's OB Service to be offered as a choice by all geographically accessible county and CBO clinics.

5. Develop and implement incentive plans for encouraging County employees to use the Medical Center and its affiliated clinics.

Explore the opportunity for the County to cover employees through a self-insurance program through an insurance carrier, making the ACMC a preferred provider under an existing health plan. Alameda County spends a great deal of money each year for the medical care of its employees. If some of this care was rendered by the Medical Center, the county would retain that money in its own system. It is in the interest of the county employees to utilize services that maintain county employment. Additionally, the presence of more patients with a choice would provide additional incentives to improve the system of care.

6. Enlist the support of area hospitals to protect the Medi-Cal patient base and to coordinate programs.

The major private hospitals are aware that the Medical Center's ability to maintain its emergency department and to be a provider of last resort is contingent on its ability to maintain its Medi-Cal patient base. Without the Disproportionate Share Hospital (DSH) payments, which subsidize indigent care, Highland would be forced to discontinue its inpatient care. The County would have to contract out indigent care at a very low reimbursement rate. Private providers will incur major losses from treating these patients. Although private hospitals are aware of this scenario, they must now come to the table ready to assist the Medical Center to retain its Medi-Cal market share and to remain financially viable.

Recommendations for Capital Improvements

7. Conduct a feasibility study on reactivating Alameda County's application for SB 1732 money for major rebuilding project at the Highland campus. Report back to the Board of Supervisors by May 15, 1996. If financial assistance from SB 1732 funds is not feasible, an alternative capital improvement plan should be developed.

There are four major facility problem areas on the Highland campus: emergency department, in- and out-patient surgery, outpatient facilities and parking. In order to address these problems, Alameda County did file architectural plans with the state in time to qualify for SB 1732 (the Construction/Renovation Reimbursement Program) financial assistance. Eligible projects are limited to construction and acquisition of fixed equipment. Medi-Cal pays a share of the project's annual debt service, based upon the hospital's Medi-Cal percentage share of inpatient days. The floor is based on 90% of the average of the three years immediately preceding the plan's filing date. In the Medical Center's application for qualifying state funds, the state share was based upon 53.8% Medi-Cal patient days. . It may be possible to redesign the project and reduce the County's debt service. The Agency will seek an opportunity to modify its SB 1732 application for greater flexibility in its project design for inpatient and outpatient use. A thorough analysis of facility capital needs at all campuses must be conducted in order to make prudent choices on future building and space plans.

8. Develop and implement a plan, including financial strategies, for immediate cosmetic improvements and renovations.

Capital investment decisions will take a long time to come to fruition. In the meantime, the Medical Center must be made to look attractive and inviting to patients. Some examples of cosmetic improvements are to remodel the main lobby at Highland, paint and landscape the facility and provide adequate multi-lingual signs.

9. Reorganize the physical layout of outpatient facilities at the Highland campus to be patient friendly.

At the Highland campus, outpatient facilities are cramped in some areas and spread out among several buildings in a confusing manner. Better use of existing clinic space would greatly improve the marketability of the Alameda County Medical Center. For example, obstetrics, gynecology and pediatrics could be placed in close proximity and scheduling could be coordinated to enable "one stop" shopping on the part of mothers and children.

10. Develop and implement a capital plan for the modernization of medical equipment.

Some of the major pieces of medical equipment throughout the Alameda County Medical Center are outmoded. Due to this, staff time is not utilized in the most efficient manner and patients do not receive state of the art treatment. Because medical equipment is very expensive it will need to be replaced over time. A plan for replacing and financing this equipment needs to be developed.

Programmatic and Operational Recommendations

11. Change the culture of the entire institution by implementing customer service strategies which address patient needs and acknowledge that clients have choices.

Managed care clients and referral sources increasingly have a choice of providers. If they do not feel welcome and valued at the Medical Center, they will take their business elsewhere. By instituting changes to make our services more customer friendly to retain managed care patients, we will create a more positive environment to benefit all patients and employees. All providers and parts of the system must work together for the common goal of transforming the Medical Center. This will need to be addressed in all staff meetings, all internal communications, and at all levels of the organization.

12. Accelerate the acquisition and implementation of a modern management information system.

A new sophisticated management information system is needed to coordinate the flow of data on individual patients among the various facilities and services. Although a system is now being developed, its planned implementation date of 1997 is too late to accommodate managed care patients this year. The timeline for its acquisition and implementation must be greatly accelerated. Many of the other recommendations contained in this report are contingent upon implementation of upgrades to the MIS and an accelerated timeline for its implementation.

13. Create systems that allow for easy access for all providers and patients to specialty clinics and inpatient services.

A frequent complaint made by CBO's, community physicians and county clinic providers is the difficulties they encounter when trying to work with the specialty clinics and inpatient facilities at the Medical Center. In order to just retain the current volume of specialty referrals and inpatient days, the Medical Center will have to make basic system improvements and create innovative

programs. An example is to allow direct admissions to the ward by community physicians. Another example is for Highland physicians, at low or no-fee, to provide in-patient services for community physicians who do not wish to follow their patients in the hospital so that the Medical Center would be able to get in-patient revenues.

14. Make the clinic appointment and registration system easily accessible to patients and providers. Develop better communication between community and the Medical Center providers.

Patients and community based providers have a difficult time accessing and utilizing primary and specialty clinics. Waiting times for some specialty clinic appointments can be two to three months. For other specialty clinics, it is impossible to make an appointment at all. At all clinics patients usually wait several hours to be seen after they arrive for an appointment. Providers and patients who have a choice will go elsewhere if services are not provided conveniently. Some ways to expand access are to increase week-end and evening hours for clinics, expand the number of examination rooms and collapse the registration and eligibility process.

15. Explore development of formal affiliations, networks, and innovative physician arrangements on behalf of the Alameda County Medical Center with area HMO's, medical centers, and physician groups.

Insurance companies are increasingly reluctant to contract with stand-alone providers. It is critical that the Medical Center not be disadvantaged in its efforts to secure managed care contracts by its potential exclusion from any of the developing Bay Area contracting networks . The Medical Center needs to focus resources and attention on managed care contracting, and on assessing the desirability of developing affiliations and joining networks for contracting purposes. In addition, the Medical Center needs to pursue creation of a Physician-Hospital Organization (PHO) to position itself in the managed care contracting arena.

16. Develop a marketing plan for Alameda County Medical Center for managed care patients

In order to maintain and expand its insured patient base, the Medical Center needs to develop a comprehensive marketing strategy, recognizing the central importance of customer service. This would include:

- a welcome package including brochures and promotional items;
- hosting an open house for managed care patients to meet medical staff;
- advertising campaign which could include newspaper ads, billboards and bus ads;
- taking advantage of free marketing opportunities such as Public Service Announcements (PSA's);
- outreach to community based providers;
- offering free health maintenance classes.

17. Develop a plan for fundraising from internal and external sources.

The Medical Center should develop a comprehensive plan to tap into private foundations, business, employee United Way contributions, and the community, for funding that could be used for strategic planning, promoting centers of excellence, cosmetic improvements, and

patient amenities or equipment upgrading to complement the County's capital improvement funding.

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The Alameda County Medical Center Task Force deliberated for many months before coming to a consensus on the best direction for the Medical Center. The following sections of this report explain the process which the Task Force followed in its deliberations, the source documents utilized and discussions held by the Task Force in formulating its recommendations.

TASK FORCE PROCESS

Alameda County has a long history of differing interests and points of view regarding the Medical Center. There has been a frustration with the planning process. The plans were either non-existent or overly ambitious. There was little follow through on what plans did exist. Players, both within and outside of the Medical Center had little faith in the process or leadership. The purpose of the Task Force was to create an objective, rational process for making some basic decisions regarding the future direction of the Medical Center. The goals for the Task Force were to:

1. Develop a common base of data and knowledge regarding the Medical Center, its patients, services and utilization.
2. Understand the health care environment
3. Define the issues to be studied
4. Look at the options and recommend a preferred option for the future of the Medical Center

The Task Force held its first meeting on September 20, 1995 and concluded its work on March 21, 1996. It had six half-day meetings and one full day meeting. The Task Force membership was very broad, representing the entire Medical Center community. Each member was extensively interviewed prior to the start of the Task Force by one of the facilitators. The Task Force heard from panels of outside experts including those representing managed care organizations and community based organizations. The topics of discussion were similarly broad. The Task Force heard reports on the strategic efforts of other counties, governance, managed care, services to be provided, medical education, finances and utilization.

Although the membership of the Task Force was very diverse, there was a commitment to an open, honest, non-hierarchical process. All members were encouraged to engage in the dialog and to be respectful of each other's point of view. Since it is often difficult to talk in a group of 35, the task force usually broke up into small groups for more intensive discussion of the issues. Many members reported that the small group discussions were the most valuable part of the process. The members were able to talk across discipline, role and facility. The process was open, objective and responsible. Within the constraints of time, all participants were able to fully participate. The facilitators worked towards consensus, whenever that was possible, and acknowledged differences where those occurred. During the course of the deliberations there was a growing sense of a shared commitment and fate among the members. That spirit is reflected in the final set of recommendations.

Membership

The Task Force membership was very broad, representing the entire Medical Center community. It included consumers, unions, medical staff, community based organizations, Medical Center administration, political leadership and other Health Care Services Agency leadership. A complete membership, staff and facilitator list is attached as *Appendix 1.*

Meeting Dates and Major Topics of Discussion

September 20, 1995

1. Introduction and discussion of the purpose of the Task Force
2. Outline and discussion of issues to be tackled: governance, fiscal options, programs, services and alternative delivery models
3. Sub-groups were given their charge
4. Report on individual interviews

November 6, 1995

1. Report on Washington lobbying trip - plan of action
2. Presentation of data packet
3. Report and small group discussion of governance report
4. Updates on other work products

November 27, 1995

1. State and Federal policy update
2. Preliminary report on the survey of other counties
3. Report on Welfare and Institutions Code § 17000
4. Discussion of governance recommendations
5. Managed care presentation and discussion
6. Program and Services Committee report

December 18, 1995

1. Committee Updates
2. Panel Presentation from three managed care organizations
3. Identification of critical issues

February 1, 1996

1. Final Report on other counties' strategic plans
2. Update on governance and current fiscal picture
3. Report and discussion on graduate medical education
4. Initial report from the program and services committee
5. Small group discussion on budget priorities

February 27, 1996

1. Panel discussion: what is expected from the Medical Center
2. Final report from the program and services committee
3. Small group discussion on services report: recommendations for reduced operating costs, promoting quality care and attracting and retaining clients
4. Small group discussion on the implementation of operational improvements
5. "Shredding the past and planting the future" - a ceremony of rededication

March 21, 1996

1. Discussion and review of Task Force Report
2. Plan for Presentation to Board of Supervisors

Task Force Sub-Committees

The Task Force set up two sub-committees which produced reports and data that became the basis for the work of the entire group. The first sub-committee was the Technical Committee, chaired by Yolanda Baldovinos. The members of this committee were: Dorothy Graham, Susan Rosenthal, Vana Chavez, Jason Lauren and Carol Oakley.

The charge to this group was to develop the data that became the common knowledge base for the entire Task Force. The work was very difficult due to the inadequate nature of the hospital's data base and management information system. Original research was done in order to complete each of these reports. This sub-committee produced the following reports:

1. Demographics of the Medical Center's patient population
2. Utilization of the Medical Center
3. Financial Information
4. Local Competitive Factors
5. Local and national trends
6. *Status Report on California's Other County Hospitals*

Attached to this report is the *Status Report on California's Other County Hospitals*. All other reports are available by request from the Health Care Services Agency.

In many ways the heart of the Task Force's work is the report of its sub-committee on services and programs. The charge to this committee was to define the scope of services to be provided at the Medical Center in the next three to five years. It was also to look at the method of service delivery. This topic is very broad and could encompass everything from a simple enumeration of the services the Medical Center wishes to provide to a comprehensive strategic plan. It took several meetings for the committee to define how it would fulfill its charge. The chair of the committee was CEO Mike Smart and the members were: Hussam El-Gohary, MD, Fran Jefferson, Jay Harness, MD, Claude Organ, MD, Ralph Silber and Gary Young, MD. This committee met eight times and commissioned Dr. Henry Zaretsky to conduct a study that evaluated three different options for the future of the Medical Center. This study is discussed in

depth in a latter section of this report and is also attached to this report. The Services Committee unanimously recommended that the Task Force approve this report. The Task force as whole followed that recommendation and unanimously adopted this report. The Task Force found the delineation of issues and options to be clear and very helpful in understanding the strategic position of the Medical Center. The final recommendations of the Task Force are based in large measure on the "Zaretsky Report".

Other Committees Giving Reports to the Task Force

Many other groups were working at the same time on different aspects of planning for the future of the Medical Center. The Task Force became a focal point for discussion of these other work groups and reports. Due to the broad representation on the Task Force it was a very good sounding board for feedback for other reports and work in progress. The other groups and studies conducted simultaneously to the Task Force were:

1. Governance Task Force chaired by Supervisor Mary King;
2. Turn Around Committee chaired by County Administrator Susan Muranishi;
3. Graduate Medical Education Study commissioned by the Medical Center administration.

The Task Force discussed at length the Governance Task Force Report. Supervisor Mary King made an initial report to the Task Force, where it was discussed in small groups. The questions and issues raised in those groups were very helpful in guiding the Health Care Services Agency Feasibility Study of the Governance Options. It also was one of the few places where an actual dialog took place between differing points of view.

Other projects and reports that regularly came to the Task Force were the Turn Around Committee, the 1115 Waiver application and the teaching program analysis. The work of the other groups, consultants and staff kept the Task Force apprised of the many facets and issues that needed to be addressed while simultaneously looking at the long term planning for the Medical Center. The Turn Around Committee's reports in particular helped focus on the very difficult day to day fiscal realities of providing county medical services.

Outside Expertise

Outside forces and organizations are continuously effecting the actions of the Alameda County Medical Center. Increasingly, the Medical Center must look at itself as part of a health system if it is to continue its mission. Not so long ago, the County Medical service was organizationally and fiscally isolated from private medical care. With the advent of managed care, integration into a countywide, or perhaps regional system of care is a necessity for survival. To better understand the environment, the Task Force heard from a panel of speakers representing three different approaches toward managed care. The speakers on this panel were Nina Maruyama from the Alameda Alliance for Health, Barbara Kempzcinska from Blue Cross and Jean Nudelman from Kaiser Health System.

Participating on a panel discussion on expectations for the Medical Center was Dr. Barbara Ramsey, Medical Director of the Native American Health Center. The community based health

centers treat the same population as the Medical Center and the problems they face in utilizing the services provide guidance for some of the needed changes.

The process at times was a little rocky, but the Task Force learned from the previous meeting and tried to make the next one more productive. The Task Force was broadly representative of the interests at the Medical Center. During the first few meetings, a lot of information and reports were presented in an effort to give all participants a common base of knowledge. Open discussion and dialog was encouraged throughout the meetings. This was particularly successful during the small group discussions. By the end of the Task Force deliberations, most of the participants felt they had learned quite a bit and had made a valuable contribution to the future of the Alameda County Medical Center. A consensus was reached on the future direction for the Medical Center and steps were identified to begin to realize that future.

TASK FORCE REPORTS AND DELIBERATIONS

Marketplace Trends - Local Competitive Factors

On November 6, 1995, the Task Force was presented with an analysis of East Bay medical marketplace trends and local competitive factors by Task Force staff member Dorothy Graham of the Health Care Services Agency.

In order to complete this analysis, Ms. Graham surveyed all the other major hospitals doing business in Alameda County, to determine what networks and alliances they were forming. She also reviewed national trends on evolution of health care markets towards formation of health care networks.

This analysis showed that Alameda County hospitals are rapidly forming into networks, with a major purpose of being able to negotiate jointly for managed care contracts, as well as to link hospitals and physicians into an integrated delivery system. In a health care network, one entity has authority to negotiate capitation contracts on behalf of all physicians and hospitals that belong to the network. This trend may be linked directly to hospitals' long term survival, in that insurers have shown a preference for contracting with networks as opposed to single hospitals.

National literature identifies five stages in the evolution of health care markets, as they move toward increasing managed care penetration and formation of health care networks:

- *Stage 1: Unstructured*
- *Stage 2: Loose Framework*
- ***Stage 3: Consolidation***
- *Stage 4: Managed Competition*
- *Stage 5: Endgame*

Our analysis identified the Oakland/Alameda County medical marketplace as being in the 3rd stage or "consolidation" phase. Local hospitals are working on different types of affiliation agreements. Some hospitals are concentrating on local integration of their institution with medical groups and IPA's, e.g., Children's Hospital with Children First Medical Group to form Children's First Health Care Network. Mulliken Medical Group, which is more active in

Southern California, is trying to enter the East Bay marketplace through affiliations with St. Rose and Washington Township Hospitals.

Other local hospitals are trying to form multi-hospital affiliations. Examples include:

- Partnership for Health (St. Rose Hospital, Washington Township)
- East Bay Indigo Network (Eden, Summit, Washington Township)
- East Bay Medical Network (Alta Bates, Eden, San Leandro Hospital, Valley Memorial/Valley Medical Center, Washington Township)

The farthest along is the East Bay Medical Network, which includes nine East Bay Hospitals which contract through Alta Bates Medical Center and Bay Physicians.

We also discussed corporate mergers, typified locally in the planned merger of California Healthcare System (which includes Alta Bates) and Sutter Health; and the movement of for-profit national chains into the area, such as Columbia/HCA Healthcare Corporation, which currently owns San Leandro Hospital and has expressed interest in more local acquisitions. These trends contain a number of risks for local hospitals, in that these companies quickly come to dominate the markets they enter. Their entry into the marketplace often results in forced closure of nearby hospitals that cannot compete.

The presentation concluded with a discussion of the implications of the local competitive factors for the Alameda County Medical Center. On paper, things look far more set than they are in reality. A number of planned affiliations have taken years to negotiate and have either fallen through or not yet been implemented. Some hospitals have joined several networks, so allegiances are not yet formed. However, we are now in a crucial period, where local health care experts estimate we are roughly eighteen months away from settling into permanent affiliations. It is critical that the Medical Center not be disadvantaged in its efforts to secure managed care contracts by its potential exclusion from any of the local contracting networks. Therefore, it was recommended that the Alameda County Medical Center needs to focus resources and attention on managed care contracting and assessing the desirability of joining networks for contracting purposes.

Governance Report and Recommendations

During the same time frame as the Alameda County Medical Center Task Force was meeting, Supervisor Mary King established a separate committee to consider governance options for the Medical Center. The recommendations of the Governance Committee were then brought before the Task Force for consideration at two meetings. At the first meeting on November 6, 1995, Supervisor Mary King presented the recommendations from her committee, that the Board of Supervisors approve transfer of governance of the Medical Center to an independent governing body, either a Hospital Authority or Non-Profit Corporation. After the presentation, the Task Force broke into small discussion groups, which were asked to respond to the following questions:

- What are the positive attributes of the two options?
- What re the negative attributes of the two options?

- Which one would you select?
- List your concerns regarding each option.
- Prioritize your top five concerns.

Positive features identified for the **non-profit corporation** included its removal from the control of the Board of Supervisors, diminished political control, "need not act in a fishbowl," and it allows for the most change and flexibility in the shortest period of time. Its **negative features** were identified as uncertainty over the status of employees, untested nature of model in California, public access not assured, likelihood that care would be rationed since the model would have to address funding shortfalls internally, and a range of labor issues including endangerment of union representation rights and increased possibility of arbitrary or capricious personnel actions.

Positive features identified for the **hospital authority** included its preservation of the Brown Act, the Board of Supervisors' role in choosing its Board of Directors, flexibility in altering work force to match market, autonomy and speed in decision making, and transitioning of current M.O.U.'s. Its **negative features** were identified as lack of a model in California, likelihood that care will be rationed; lack of public oversight or involvement; requirement for enabling legislation; and decreased job security with an increased possibility of arbitrary or capricious personnel actions. Those who preferred the non-profit model expressed concerns that the hospital authority would still have continued political control and that the Brown Act requirement would lead to delays.

The **prioritized concerns** from the small group discussions included the following issues:

- How will any of these models **concretely help to save the Medical Center?**
- **Continued financial support** for the models - what would be financial support if revenues changed: county support vs. other sources of revenue;
- **Process for dissolution** if determined necessary in the future
- Would the hospital remain a **public hospital?**
- How would these models be expected to make up **loss of outside funding support**?
- **Public accountability** - public needs opportunity to be heard and informed; need for open information.
- **Next steps for feasibility study**: who will be involved? What criteria will be used? Need to study the Monterey commission model more, need to look at actual examples of how the non-profit and authority models have worked in other places outside California.
- **Governing Board politics**; composition of board; potential conflict of interest.
- **Employee's status** and protections under the new governance structure.

The following major themes were identified to summarize the day's discussion by the Task Force facilitator, Martin Paley:

- **Flexibility**: is desirable and part of our ability to survive and compete; must have an ability to adopt to changing conditions.
- **Level of Political Involvement**: Board of Supervisors' influence on either non-profit or hospital authority;

- **Understanding county obligation**; need information and communication; if Medical Center goes under, who is prepared to take care of our indigent patients?
- **Accountability** to the people the Medical Center is supposed to serve; indications of accountability were identified as: is there a mechanism to assess and alter performance? Is there open information?
- **Commitment to Employees**: includes both job protections and ability under new system to use employees in flexible ways.
- Recognition of **Stakeholders in the Medical Center**: employees, patients, physicians, Board of Supervisors, "payors", the federal and state governments, the public.

Feeling that they did not have a chance for prior review at that point, most of the small groups at the November 6th meeting declined to indicate a preferred governance model. At the subsequent meeting of the Task Force on November 27, 1995, after having had an opportunity to review the Governance Report, the Task Force was asked to make a recommendation to the Board of Supervisors for the hearing on December 5, 1995, concerning recommended governance options. The Task Force voted with a 60% majority (13 to 9) that a third governance option, the commission model, should be added for study in the next phase of work, to the feasibility study.

The Task Force voted on their preferred option. No single option received a clear majority. The vote was as follows:

- 6 Non-profit
- 3 Hospital Authority
- 9 Commission model
- 5 Either non-profit or hospital authority

- 23 **Total votes cast**

While there was not a clear consensus on a preferred governance model at the Task Force, there was general agreement that the status quo was unacceptable and that a change is required. There was consensus that a competent group of health care experts is needed who would devote themselves to issues concerning the Medical Center.

Status Report on California's Other County Hospitals and Health Systems

Alameda County is not alone in facing the issues and dilemmas regarding the provision of health care services to its indigent population. All other counties in California operate under the same responsibilities delineated in the Welfare and Institutions Code 17000. This report was prepared for the Task Force by Susan Rosenthal and Dorothy Graham, to investigate what the other counties with county hospitals are doing to discharge this responsibility. This report represents four months of intensive research and interviews with county hospital CEO's, CFO's, and other top administrators in fourteen other counties. This report provides very useful information on the trends and direction of the hospitals and health systems surveyed. Many of the recommendations for policy, operational, and capital changes at the Alameda County Medical Center grew out of the discussion of this report.

Although each county is unique, many common factors are facing public hospitals and health systems in California as they strive to position themselves for the future:

1. The number of uninsured in California is on the rise - increasing those who depend on the county safety net for care.
2. A trend of declining hospital occupancy has led to empty beds in the private sector which has been wooing Medi-Cal patients, traditionally left to the public sector
3. County budgets have been declining leading counties to pull general fund money out of hospitals.
4. Public hospital infrastructure is declining, with most occupying aging, outmoded and seismically unsafe buildings.
5. Disproportionate Share Hospital (DSH) funding, which has been used by the public sector to support indigent care, has been declining.
6. The advent of Medi-Cal Managed Care has accelerated the pressure on county hospitals to become competitive in order to retain their share of Medi-Cal patients.

Counties have generally responded to these factors in one of two ways - most have made a renewed commitment to maintain their hospitals and adapt them to the challenges of the new environment. A second group have decided to sell, lease or merge their facilities and abandon their role as direct providers of inpatient care. This report presents information on counties that responded in both ways. It synthesizes the strategies used by other counties to make themselves viable and competitive in the managed care marketplace. County hospitals and health systems are developing plans to make themselves attractive to Medi-Cal and other paying patients and to run more efficiently. This report includes a discussion of the fiscal and competitive situation of other counties. However, the Los Angeles County situation was considered too different and complex to include with this analysis. A separate package of information on Los Angeles can be provided upon request.

County hospitals and health systems are at a critical juncture in their existence. Counties that have made a commitment to survival through aggressive strategies to maintain their payer mix and compete under managed care are: Contra Costa, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara and Ventura. A second group of counties that are attempting to sell, lease or merge their facilities are: Fresno, San Luis Obispo, Sonoma and Stanislaus. Kern County has not yet decided on a strategy.

County Medical Center Chief Executive Officers of the hospitals which are committed to a long-term future, shared with us their common philosophy about the importance of the safety net, as explained in this paragraph. Their first decision was whether to be in the business or not. Those county hospitals which decided they were in the business to stay, have adopted aggressive strategies for survival. They believe that even though private hospitals may have empty beds, they do not have the mission or mandate to serve the indigent. County hospitals serve every patient without discrimination. Private hospitals statewide have been unwilling to make long term commitments to care for the indigent. If the county were to close its hospital, the privates would be in the drivers seat in future rate negotiations and the county would not be able to control its costs. The counties that have decided to compete decided that they would not let the private sector "cherry pick" the most profitable of the Medi-Cal patients. These counties

concluded that due to the link between Medi-Cal and indigent funding, becoming competitive is the only way to ensure the continued ability to serve the indigent.

COUNTY COMPETITIVE STRATEGIES

Those counties which decided that they are in the business to stay have adopted a range of strategies to further that goal. These strategies fall into seven broad categories:

1. Capital Improvements - renovations, rebuilding, remodeling
2. Information System Investments
3. Creating new services and exploiting existing specialized services
4. Operational Improvements
5. Capturing New Clients - expanding the referral base
6. County Health Plan Development
7. Local Initiative Policies

1. CAPITAL IMPROVEMENTS

Almost all counties with hospitals have embarked on fairly extensive rebuilding, remodeling and renovation projects in the last several years. Building was spurred by the availability of SB 1732 construction funding from the State. Hospitals that meet the program requirements receive very significant assistance through the Medi-Cal program in financing their capital projects. The State Medi-Cal program will pay a share of the annual debt service payments based on the hospital's percentage of Medi-Cal days. The floor for what a county can receive is based on 90% of the average of the three years immediately preceding the filing date of the plans. The debt financing takes a majority vote of the Board of Supervisors. Although the General Fund has the ultimate responsibility to pay, the hospitals are planning to repay the debt service from new revenues, savings generated from the new facility, cost cutting and efficiencies.

Eight counties are rebuilding the entire hospital or a substantial portion of it - Contra Costa, Santa Clara, San Mateo, San Joaquin, Monterey, Riverside, San Bernardino and Ventura. In each case the impetus was an old facility that is inadequate and seismically unsafe. However, the new facility is a major factor in the county's plan to be competitive. The new hospitals are being designed to accommodate the change to outpatient care, are in most cases smaller than the original and will consolidate services as well.

Counties are making other capital investments into their health care system. San Francisco General Hospital is building a garage. Many counties are making cosmetic changes and remodeling their inpatient facilities from internal savings (San Bernardino, San Francisco, Monterey, Fresno, Ventura, Kern). Most counties are expanding their outpatient free standing clinics, either through purchase of existing buildings or building and remodeling their own facilities.

2. INFORMATION SYSTEM INVESTMENTS

Counties have invested resources into their information systems for better decision making and patient management. San Francisco has the most ambitious project - a $25 million system

which ties the entire county health system into a fiber-optic network with on-line access to medical records.

3. CREATING NEW SERVICES AND EXPLOITING EXISTING SPECIALIZED SERVICES

Many counties have started new services to manage their patients better and to be more efficient. Some examples of these new services are:

- ◊ Fast track patients who come into the Emergency Department. They are seen by a nurse practitioner and not a resident.
- ◊ Creating a primary care clinic earmarked for only managed care, workers comp., employees or other insured patients.
- ◊ Advice nurse program
- ◊ New urgent care clinics
- ◊ Telephone prescription renewal system
- ◊ Marketing women's health care
- ◊ Geriatric services

4. OPERATIONAL IMPROVEMENTS

Clients and resources must be efficiently managed or capital investments will be wasted. Many of these improvements take an initial financial investment. Some examples of operational improvements are:

- ◊ Expanded hours for urgent care clinics
- ◊ Same day appointments
- ◊ Managed care patients moved to the head of the line for clinic appointments and parking
- ◊ Active monitoring of productivity
- ◊ Active monitoring of clinic waiting times
- ◊ Flattening organization
- ◊ Emphasis on a customer orientation
- ◊ Integrated case management team to ensure proper utilization of hospital services and enhance marketability to managed care organizations
- ◊ Exit and satisfaction surveys on all clients
- ◊ Staffing efficiencies
- ◊ Round the clock telephone triage system and automated appointment system

5. CAPTURING NEW CLIENTS: EXPANDING THE REFERRAL BASE AND MARKETING

County hospitals are changing to meet the needs of other primary care providers in the community. In order to retain voluntary admissions, they are creating stronger networks with

other providers. These counties are going after an expanded patient base through a variety of mechanisms:

- ◊ Requirement or strong encouragement for CBO's and county clinics to admit to the county medical center
- ◊ Creating IPA's and Physician-Hospital Organizations (PHO's) to market to insurance companies
- ◊ Discounts for private Workers Comp. services
- ◊ Going after the Medicare market through the creation of a continuum of care
- ◊ Setting up provider support and marketing departments
- ◊ Direct admissions from private physicians
- ◊ Campaigns to get patients to identify county as their PCP when first enrolled in Medi-Cal
- ◊ County hospital attending physicians acting as in-patient MD for community doctors at low or no fee

6. COUNTY HEALTH PLAN DEVELOPMENT

Six of the counties surveyed have county health plans (county HMO's) at various stages of development. The most developed are Contra Costa and San Mateo. The others are San Joaquin, Ventura, Riverside and Monterey. These are county HMO's which use county clinics and county hospitals to provide services to their members. Additionally, in Santa Clara County new employees are required to get their health care from the county during their first year of service. After one year, they can switch providers. The health plan in Contra Costa County has been in existence for many years and serves county employees, the general public and public welfare recipients. San Mateo is a county organized health system. All Medi-Cal recipients receive their care through the Health Plan of San Mateo - which is a separate legal entity from the county.

Common features to county health plans which serve county employees are financial incentives to use the county medical center, health promotional activities and often a separate outpatient clinic.

7. LOCAL INITIATIVE POLICIES

Nine of the counties surveyed are establishing local initiatives. Most are consciously utilizing their local initiative to strengthen the safety net and county run services. Examples of policies that protect the role of safety net providers are:

- ◊ Contracting only with Disproportionate Share Hospitals
- ◊ Defining the safety net as those that serve the indigent as well as Medi-Cal patients.
- ◊ County hospital has the right of first refusal to provide specialized services
- ◊ County facilities are favored in default enrollment
- ◊ Traditional providers defined as those with a very high (75%) Medi-Cal clientele
- ◊ County has significant representation on the Local Initiative Board

HOSPITALS WHICH ARE CLOSING, BEING SOLD OR MERGING

The survey includes four counties which have made decisions or are studying options for sale, transfer of their facilities or closure of their in-patient services. The counties are Fresno, Sonoma, San Luis Obispo and Stanislaus. These counties cited a number of factors leading to these decisions:

- ◊ Falling hospital census
- ◊ Small uninsured caseload
- ◊ Facilities in need of extensive capital investment, but the counties did not pursue SB 1732 financing
- ◊ Projected state and federal funding losses

Approaches range from leasing to a private hospital chain to contracting out to a private sector hospital to merging with a private hospital. Some are also looking for a partner who will make a capital investment. Sonoma County is the only county that has actually implemented its plan. Its hospital was sold to the non-profit Sutter Health System. However, there will be an citizen sponsored initiative on the ballot that seeks to undo this decision.

There are many unresolved issues for the counties still studying this option:

- ◊ Loss of control of the cost of care for the indigent
- ◊ Private health systems do not know how to care for the indigent population
- ◊ What will happen to Federal and State money i.e., SB 855, Medi-Cal and Medicare education reimbursements
- ◊ How to structure the payment for indigent care
- ◊ Transitional costs of closure or merger
- ◊ What happens to trauma and other specialized services

COUNTY HOSPITAL FINANCIAL PICTURE

This survey looked at many factors concerning the financial status of county hospitals. Eight of the county hospitals reported receiving a general fund contribution. The average contribution amongst those receiving this funding is $9.7 million annually. Most counties noted a decline in general fund contributions over the past three years. Ten of the county hospitals receive realignment dollars. Realignment funding was steady in most counties, although several reported that the funding had been partially redirected to public health. Net county contribution to the public hospitals ranges from 1.3% (Stanislaus) to 27.7% (San Francisco), with an average of 14.2%.

A majority of county hospitals reported a deficit in the past two years. Deficits for fiscal year 95/96 ranged from a low of 3.6% to a high of 24% with an average of 10.7%. The reasons given for the shortfall was a loss of SB 855 funding, a loss of realignment funding, loss of SB 910 funding, inflationary cost increases, exhaustion of prior year trust fund revenues and declining census. Counties closed the revenue shortfall in a variety of ways, which included: SB 855, reducing the use of temporary employees, attrition, one time revenues, reduction in professional contracts, an increase in general fund contributions, past FQHC claims, elimination of unfilled positions, furloughs and layoffs.

SUMMARY

Several themes emerged from the study of other county hospitals and health systems. County hospitals have historically been very traditional. Many are now demonstrating a resiliency not usually associated with traditional bureaucratic organizations. Accessibility to primary care is being emphasized as well as a responsiveness to patients and community providers. Counties that have made a decision to maintain their mission to directly provide health services have committed significant resources in time, money and personnel to ensure their viability. Each county has a unique situation; but all are facing a common environment. The plans and experience of the other counties are a useful spur to creative thinking and planning in Alameda County.

Small Group Discussions - Exercise on Budgetary Priorities - February 1, 1996

On February 1, 1996, the Medical Center Task Force heard an extensive presentation on what other county hospitals and health systems throughout California are doing to position themselves to survive. They also heard a preliminary report from Dr. Henry Zaretsky on his evaluation of options for the future of the Alameda County Medical Center. After these presentations, the Task Force broke down into three work groups, to develop budgetary priorities for the Medical Center They were had received on the Medical Center's current fiscal picture presented by Chief Financial Officer Carol Oakley.

The three work groups were each asked to address four major areas in their discussions:

- **What are the areas of deficit reduction which the Medical Center could consider?**
- **What would be the most promising areas for bringing in increased revenues?**
- **What organizational changes would be most important to address?**
- **What should be our stance/ what should we try to achieve in relationships with other providers?**

After an hour of discussion, the groups reconvened to present their recommendations. A compilation of the findings from the three work groups appears below in an abbreviated form.

What are the areas of deficit reduction which the Medical Center could consider?

- Reduce staff numbers and examine the pattern of staffing.
- Adjusted staffing ratios; analysis is needed to compare ACMC with similar facilities.
- Salary comparisons for competitive mode.
- Protect areas of excellence <u>now.</u> They are our future.
- There is a need to recognize that the lack of any County General Fund support of ACMC is contributing to the deficit.

- Implement a plan to regain the $10 million in revenues lost when the Fairmont acute wards B-1 and B-2 were closed last year. For FY 96-97, either proceed with plan to open 5 West at Highland to recoup these patients, or reopen Fairmont ward.

What would be the most promising areas for bringing in increased revenues?

- Increase service to the county clinics or CBO's (community based organizations).
- Increase or start new centers of excellence, e.g., like orthoscopic surgery for privately insured patients.
- Increase our special "niches" book of business. Market specialized services, such as ancillary services to the Mental Health population, Rehabilitation, and transitional care.
- Create special inpatient and outpatient units for insured patients.
- Grant admitting privileges to Highland for county and CBO physicians.
- Patients coming to Highland Emergency Department have private MD's in some cases who do not have admitting privileges. Either offer them admitting privileges or provide inpatient care for their patients.
- Attending or resident physician could take inpatient responsibility for community physician patients.
- Obtain research and development seed moneys.
- Develop an ACMC insurance plan in partnership with Alliance.
- Develop Occupational Health Services for county employees.
- Advertise our services, using billboards and other marketing means used by competing hospitals.
- Provide Workers' Comp services exclusively for county employees, as does San Francisco. Develop Workers Comp module at Fairmont Hospital.
- Assessment district can bring in additional revenues for trauma care.

What organizational changes would be most important to address?

- Change name of facility - new logo - different attitude.
- Change governance.
- Need a Medical Director.
- Develop a corporate vision and values.
- Different relationship with the unions - joint partnering, joint planning.
- Install an excellent management information system on a timely basis.
- Improve billing operations and collections.
- Bill appropriately for services; We are at least 10-20% lower than private sector on pharmaceuticals. Our charges are not upgraded more than every 3-5 years.
- Need a better way to identify patients who are potentially Medi-Cal eligible. Many with serious problems are eligible. All patient advocates have been eliminated.
- Review current departments and assess organizational structure.
- In order to run more efficiently, it will require an initial investment to reap ongoing savings.

What should be our stance/ what should we try to achieve in relationships with other providers?

- We need to send a strong message to other providers, asking them to stop "cherry picking." They need to understand that either we need our (Medi-Cal) patients back or we will need to close, and they will have to be prepared to absorb our indigent patients.
- Collaborate with community facilities to insure minimum levels of Medi-Cal patients remain with the Alameda County Medical Center.
- To develop a better relationship with County Mental Health, change how mental health patients are treated at the Highland Emergency Department. Change how mentally ill are treated. Do away with the red gowns. It was acknowledged that physicians have problems with how the ER is laid out, but it was still felt there is an attitude problem that has to be changed.
- Hold a summit meeting with CEO's and Medical Leadership of other East Bay hospitals - to discuss vision for Alameda County Medical Center.
- Explore opportunities for joint venturing and joint partnering with community. Look for any opportunities to consolidate and regionalize care.
- Hold a summit meeting with the community based organizations to work towards a unified delivery system.
- Concerns were expressed that other providers are deriving benefit from ACMC being here to serve the indigent, but they are not putting anything in to assure we can maintain these services.
- Change rule that Highland can't go on diversion when our beds are full. This rule is only applicable in our County.

Overall , the groups wished to convey to the Board of Supervisors that some of the most beneficial options for improving the Medical Center operationally, and hence increasing its revenues, will require an initial investment. There was a strong sense of accomplishment from the groups, and a feeling that the discussion had been very productive across departments and disciplines. This is the essence of the Task Force experience which needs to be preserved and continued into the future.

Small Group Discussions - Analysis of what the Medical Center Must do to Prepare to Serve Managed Care Patients - February 26, 1996

At the all-day work session held on February 26, 1996, the Medical Center Task Force again broke into small groups. The groups identified address the priority issues which the Medical Center must address in order to attract, serve, and retain managed care patients. An immediate need is to satisfactorily serve the AFDC Medi-Cal enrollees through the Alameda Alliance for Health. The Task Force broke into four work groups, each with a charge to outline tasks, responsible person and timeline. At the end of the day, the four groups reconvened and reported on their plans There were many areas in common. Staff at the Medical Center, Joni Thomas and Meckila Pierce, have now taken this process to the next level. They have developed a coordinated plan based on the small group discussions, eliminating duplication, identifying gaps, and assuring that appropriate staff are assigned to carry out all identified tasks. (See Next Steps - Where do We Go From Here?).

The recommendations from the small group discussions have further been integrated with the implementation tasks recommended in Dr. Henry Zaretsky's report for a comprehensive work plan, with key elements as outlined in the "recommendations section" of this report.

THE CHOICES WE FACED: Evaluation of Options for the Future of the Alameda County Medical Center - by Henry Zaretsky, Ph.D.

The Alameda County Medical Center contracted for a study conducted by Dr. Henry Zaretsky, a leading health economist and strategic planning consultant who has assisted county hospitals in determining their futures. His assignment was to guide the Task Force's work in studying options for the intermediate future role of the Medical Center. The Services and Delivery Committee played a very active role in working with Dr. Zaretsky, both in shaping the issues which he was to study, and providing review and comment on the work in progress. The Services Committee endorsed Dr. Zaretsky's report and recommended that the full Task Force urge its adoption by the Alameda County Board of Supervisors. Dr. Zaretsky also made two presentations to the full Task Force on his data analysis and conclusions. At its full-day work session on February 26, 1996, the Task Force unanimously endorsed Dr. Zaretsky's report, *Evaluation of Options for the Future of the Alameda County Medical Center*, and agreed to carry forward his recommendations for adoption by the Board of Supervisors.

Scope of Study

The scope of the study was to assess three major models for the future role of the Alameda County Medical Center over the intermediate term (i.e., the next five years.) The three alternative models are as follows:

(1) ACMC as a "treat and transfer" facility, where the Highland campus hospital would maintain its trauma center designation and largely restrict its inpatient services to trauma and emergency patients. These patients would be transferred to other hospitals upon stabilization. County-obligation patients (County Medical Services Program - Section 17000) who are not emergency admissions would be treated in private hospitals under contract with the County.

(2) ACMC as a treat and transfer facility and as the CMSP hospital. Non-CMSP patients who are not emergency patients would in general be treated in other hospitals. The Medical Center's payor sources would primarily be CMSP and private and public sponsors of trauma/emergency patients admitted to ACMC.

(3) ACMC as a "full service competitive hospital," retaining its current role as a trauma center and the major CMSP provider, as well as a major Medi-Cal provider and source of care for patients of all payor sponsorships.

Dr. Zaretsky was also asked to address mechanisms for coordinating efforts with private hospitals, and to set forth conditions for contracting with private hospitals.

Dr. Zaretsky evaluated the three models in terms of their likely impact on volume, revenue, expenses (both operating and capital) and service capability. The primary source of data was special reports generated by Natalie Curson of ACMC Information Systems Department on

volume and charges for calendar year 1995, broken out according to service, payor source and admission source.

In the course of Dr. Zaretsky's work, he was requested by Martin Paley, Task Force facilitator, to add a fourth option to consideration, which would be for the Board of Supervisors to close ACMC as an inpatient facility, and to contract with private hospitals to meet its Section 17000 obligations.

Study Conclusion

Dr. Zaretsky concluded that the first and second services options are not viable for reasons summarized below. He found there were only two options that are feasible from a financial or services standpoint: maintain ACMC as an institution capable of attracting a sufficient Medi-Cal revenue base, and related DSH subsidies, or cease inpatient operations altogether, and contract with the private sector for county-obligation patients. However, Dr. Zaretsky would recommend consideration of the private-sector option only with protections and long-term guarantees, that he believes private hospitals would be unlikely to consider.

The major conclusion of the report was that **given existing payment mechanisms, where a major portion of state and federal funds used to subsidize county-indigent patients is derived through the Medi-Cal program in the form of disproportionate share payments, the only feasible alternative is for ACMC to continue to be a high-volume Medi-Cal provider. Given the movement to Medi-Cal managed care and competitive pressures in general, ACMC must take initiatives - capital investments and programmatic changes - to be a competitive hospital. Failure to do so would result in Alameda County being unable to support its Section 17000 obligation without substantial general fund expenditures, either directly through operating its own hospital, or indirectly, through private sector contracting.**

The Environment

Dr. Zaretsky's study acknowledged the extreme pressures and challenges facing ACMC as well as other county operated health systems. The funding sources for ACMC are increasingly becoming more restrictive. County general fund revenues are no longer a predictable source of funds and in fact there is no longer a general fund subsidy of the Medical Center except for its Ambulatory Care Department. The Medical Center's ability to provide necessary care to county indigent patients is dependent upon its ability to attract a sufficient number of Medi-Cal patients.

That ability is severely threatened by competition from private hospitals with increasing excess capacity. While county hospital funding may be less secure, inevitable cuts in overall Medicaid funding, without establishment of a national health insurance program, will lead to an expansion in the number of county-indigent patients.

The ability to successfully compete for Medi-Cal patients will require capital investment on the part of ACMC so that its facilities and services will attract Medi-Cal patients with private sector choices. If ACMC is unsuccessful in its efforts to protect its funding sources, it is likely the County will not have sufficient resources to meet its indigent care responsibilities through

private-sector contracting. This shortfall in resources will largely be the result of the loss of The Medical Center's disproportionate share hospital (DSH) funding in the coming fiscal year. *(Note: since the publishing of Dr. Zaretsky's report, the projected DSH shortfall has decreased from $15 million to $10 million.)*

These funds are not transferable to private hospitals. To qualify for DSH requires high Medi-Cal and/or unsponsored patient loads. There is approximately a two year lag between achieving these volumes and attaining qualification. Should ACMC cease to operate as a general-acute hospital, there will be a major tug of war between the County's indigent care obligation and the private hospitals' abilities and willingness to accommodate large numbers of these patients without payment.

Findings and Recommendations on the Service Options

1) Treat and Transfer Facility

Under this scenario, ACMC would only be a trauma/emergency hospital. Once patients are stabilized, they would be transferred to other hospitals. Outpatient services would continue to be provided at both campuses. All inpatient services on the Fairmont campus would be discontinued. All inpatient services provided at either campus to CMSP patients who are not trauma/emergency or have been stabilized would be provided at other hospitals under contract. Other county-obligation patients, such as jail patients, would have to also be accommodated in private facilities.

It should be noted that for his analysis, Dr. Zaretsky considered a number of sub-options within the general "critical care hospital" scenario. A restrictive definition based on patients identified as "trauma" would yield an average daily census of 12, requiring approximately 20 beds, and an average daily charge of $5,472. For the broader category of emergency inpatients, the census rises to 87, requiring 125-145 beds, and average daily charges would be $2,386.

Dr. Zaretsky concluded that because of the low volume associated with this type of facility, its practicality is doubtful. To be a trauma center, a hospital must provide a fairly comprehensive array of inpatient services, and have substantial back-up personnel and facilities. If volume falls between 38 and 86 percent as the report projects under this option, an adequate patient base to support a full-service hospital would not exist. In general, hospitals of substantially less than 200 beds in urban areas do not make economic sense.

Another problem is the loss of substantial DSH payments, which are tied to Medi-Cal patient days. Such losses would have to be offset by substantial general fund appropriations to enable the County to meet its Section 17000 obligations through contracting with private hospitals. All non-trauma/emergency indigent care would have to be contracted to the private sector. With projected DSH losses of $12-24 million in FY 95-96, and $6 to $14 million in FY 96-97, private hospitals would be required to incur aggregate losses which would approach a similar magnitude. These losses would only be partially offset by profits gained from receiving the Medical Center's former Medi-Cal patients.

2) Trauma Center and an Indigent Hospital

Under this scenario, ACMC would remain a trauma center, treating all trauma patients, regardless of payor source, and be the primary hospital provider for CMSP patients. CMSP patients would be treated regardless of admission status. Non-CMSP patients, however, would only be treated if they were trauma patients, and once stabilized, transferred to other hospitals.

The implications of this scenario are similar to those pertaining to the treat and transfer model with one exception. CMSP patients would continue to be treated at ACMC, rather than contracted out to the private sector. However, Dr. Zaretsky concluded that this option is not financially viable. It would result in the loss of virtually all DSH revenue, which would have to be replaced by County General Fund dollars, (nearly $30 million in the current year.)

3) A Competitive Full Service Hospital

Under this scenario, ACMC would retain its current patient base and take initiatives necessary to maintain that base through the remainder of this decade and beyond. In the last year, ACMC has experienced a drop in its Medi-Cal obstetrics patients due to competition from the private sector. To effectively compete for this vital market segment will require efforts on the part of ACMC to emulate private providers in terms of services and amenities. Data analyzed by Dr. Zaretsky shows that Medi-Cal (excluding mental health and nursery) accounts for 57% of total patient days. The cost per patient day for Medi-Cal patients is estimated to be $1,961.

Dr. Zaretsky's report provides an in-depth analysis of the volume, necessary capacity, revenue and expenses under option #3. He found that at the Highland campus, there is an average daily census of 126, excluding mental health and nursery. This ADC is consistent with a need for roughly 175 beds. While Highland campus is currently licensed for 236 beds, many of these no longer exist. There are 191 available beds at the Highland campus, which Dr. Zaretsky determined is in line with the needed capacity. He also analyzed the Medical Center's relative market position compared to other hospitals in Alameda County. **ACMC accounted for 47% of all Medi-Cal patient days in Alameda County.** In the mandatory aid categories (AFDC related), ACMC accounted for approximately 23% of patient days in Alameda County.

Perhaps the most revealing data in the report was Dr. Zaretsky's analysis of Medi-Cal paid claims data for years 1992 - 1995. Dr. Zaretsky found that in 1992, Medi-Cal patient days in the AFDC mandatory aid codes were 28% for ACMC and 29% for Highland. This amounted to 8,319 patient days in the mandatory aid codes. By 1995, the total number of Medi-Cal patient days for Highland remained similar at 27,824, but the number in the mandatory aid codes had dropped to 21% or 5,933. Of these 1995 days, 29% are in obstetrics.

Dr. Zaretsky then analyzed how many beneficiaries would have to be enrolled in the ACMC system in order to retain these patient days. He examined the countywide data on inpatient utilization rates for the AFDC population and found it to be 265 days per 1000 enrollees. This projection, however, does not account for the likely drop in utilization under managed care. The implication is that the number of enrollees needed to maintain these days is likely to be significantly higher than the numbers shown in his report. **Thus, a very conservative estimate based on 1995 days, would require that there be 22,364 AFDC beneficiaries assigned to the ACMC system, of which 13,423 must be adults.** These estimates acknowledge that children enrolled in the ACMC system would be treated at ACMC clinics but hospitalized at

Children's Hospital. Highland's Medi-Cal patient base would need to be protected through a combination of enrolling a sufficient number of adults through both the Local Initiative and commercial plan at all Medical Center sites, and through referrals for inpatient care from other network providers.

If ACMC is unsuccessful in its efforts to protect its funding sources, it is likely the County will not have sufficient resources to meet its indigent-care responsibilities through private sector contracting. This shortfall in resources will largely be the result of the loss of the Medical Center's DSH funding of approximately $30 million in the current fiscal year and an estimated $15 million in the coming fiscal year. These funds are not transferable to other hospitals.

Appropriate Strategies to Achieve Option # 3

Dr. Zaretsky noted a number or reasons why private hospitals have moved aggressively to expand their Medi-Cal patient base, ranging from higher prenatal care and delivery reimbursement rates to declining inpatient utilization as a result of managed care proliferation in the private sector. As a result, he concluded that ACMC should expect to have to compete to retain its Medi-Cal base in the mandatory aid categories. It should not be forced to have to make considerable capital investments purely for marketing reasons, but to remedy current deficiencies. ACMC should capitalize on its competitive position in terms of a committed medical and support staff accustomed to dealing with hard to manage patients, its capabilities due to its extensive teaching program, its dependability at a time when the desirability of Medi-Cal patients to many private providers may be only a fad, and its integrated health system involving a network of county operated and private clinics linked to ACMC.

Capital Investments

Dr. Zaretsky recommends that ACMC should consider reasonable efforts to maintain its plant and equipment in a cost-effective manner in the next three - five years. The main Highland building has four major problems which demand attention:

1) The emergency department is in need of major renovation
2) The surgery facilities (inpatient and outpatient) are inadequate
3) Outpatient services are cramped in some areas and spread out among several buildings in a confusing manner
4) Parking space is inadequate

Dr. Zaretsky, as part of his analysis, confirmed Alameda County's current eligibility for SB 1732 funding for a building project to remedy these problems.

SB 1732 established the Construction/Renovation Reimbursement Program as part of the Medi-Cal program. Eligible projects must be available to Medi-Cal patients, must be on behalf of Medi-Cal contracting hospitals, must be financed through tax-exempt debt, and projects are limited to construction and acquisition of fixed equipment. Medi-Cal's share of the debt service is determined by the hospital's Medi-Cal percentage of inpatient days.

Architectural plans for the ACMC project were filed with the Office of Statewide Planning The capital plan proposed by Alameda County in 1994 was for an eight story critical care building and parking structure. The critical care building was to include emergency/trauma facilities, intensive care beds, an imaging center, and shelled clinic space. The cost of the project was estimated to be $90 million (this estimate excludes costs for furnishings, equipment, financing costs, capital reserve fund, and other incidentals). Since the plans incorporated only shelled space for a portion of the building (which does not qualify for SB 1732, since the space must be ready to be available for use in order to receive matching funds) approximately $60 million of the planned capital expenditures would qualify for SB 1732 assistance. **Thus, assuming ACMC's Medi-Cal patient-days percentage is approximately 50%, SB 1732 would yield $30 million in subsidies.**

Non-Capital Intensive Measures

Dr. Zaretsky recommended that ACMC also implement strategies that capitalize on its major attributes, of familiarity with the medical, cultural and linguistic needs of the indigent and Medi-Cal populations.

He recognized the Medical Center's potential to form the nucleus of an integrated health care delivery system, which would include long term care at Fairmont, mental health facilities (John George Pavilion), public health, a network of county operated and CBO clinics, and extensive specialty resources through its teaching program. To take full advantage of its potential would require investments in necessary information systems to coordinate the flow of patients and data among the different facilities and services.

Dr. Zaretsky recommended that coordination among these components in the Medical Center's best interests requires at a minimum that the first choice for hospital and medical specialty referral on the part of all affiliated clinics is ACMC. Unless there is a distance problem or ACMC does not have the required services, (e.g., pediatric inpatient,) all clinics, including CBO's, should be required to refer within the ACMC system. Dr. Zaretsky recognized that for such coordination to work requires the ability of the Medical Center's programs to accommodate the referring clinics through timely appointment scheduling. He recommended that physicians representing the ACMC, CBO's, and other community physicians be brought together to identify improvements needed at ACMC to facilitate establishment of an expanded referral base.

Reconfiguring some of the clinics to be more "patient friendly" could also enhance the Medical Center's marketability. For example, obstetrics, gynecology, and pediatric clinics could be placed in close proximity and scheduling could be coordinated to enable "one-stop" shopping for mothers and children.

Dr. Zaretsky noted that some other public hospitals have established two tracks for patient care, one for Medi-Cal and insured patients, and another for CMSP. This may be controversial but should be explored, since to the extent it contributes to the financial viability of the Medical Center, access for all patients can be improved.

The teaching program provides an opportunity for ACMC to enhance its reputation in various medical specialties and its private patient base. In cooperation with private hospitals, for

example, ACMC could develop certain "centers of excellence," such as disease management for cancer patients or workplace injuries.

Efforts should be made to encourage county employees to use ACMC and its affiliated physicians through financial incentives, in terms of reduced health insurance premiums, deductibles, or coinsurance.

Another mechanism to retain Medi-Cal managed care patients is through the Local Initiative (Alameda Alliance for Health). Dr. Zaretsky recommended that enrollees should be encouraged to select primary care providers (i.e. county clinics and CBO's) affiliated with the Medical Center, and that those enrollees who are unable to make a selection should default into the ACMC network.

Dr. Zaretsky stated that "the importance of marketing the ACMC system to the Medi-Cal population cannot be over-emphasized." He explained the experience of the University of California at Davis, which failed to aggressively market under Geographic Managed Care. He concluded that UCD elected not to exploit their positive attributes during the early stages of enrollment and has been unable to recover.

Finally, Dr. Zaretsky recommended that the support of the private hospitals should be enlisted to protect the Medical Center's Medi-Cal base and coordinate programs with ACMC. Once they understand the risk which loss of DSH poses to ACMC's continued ability to operate a trauma center and to serve the indigent, the private hospitals could be receptive to enactment of Local Initiative policies to protect ACMC's Medi-Cal patient base.

Coordinating Efforts with Private Hospitals

Dr. Zaretsky concluded that the only possible viable alternative to the Medical Center becoming a full-service competitive hospital capable of retaining its Medi-Cal base, would be to cease inpatient operations altogether and contract with private hospitals to fulfill its Section 17000 obligations. He recommended that if the Board of Supervisors were to make such a decision, it should be guided by a policy based on the following:

1. The private hospitals should make a legally binding, long-term (i.e. 25-30 years) commitment to provide mainstream care to all patients in need of such care. It must be a long term commitment because once the county medical center is closed, it is unlikely ever to open again.

2. The hospitals' track records in treating the indigent should be established. Dr. Zaretsky noted the that the county medical centers' patients have a myriad of social and medical problems that are difficult to manage, requiring medical and allied-health personnel with particular sensitivities.

3. The general fund exposure to the County should be reasonable and predictable. It is currently zero. He noted that the private hospitals would be the beneficiaries of substantial incremental revenue and patients to fill up their empty beds, especially from the county hospital's former Medi-Cal patients.

4. The private hospitals should coordinate and integrate services among themselves in their community's best interests, and should be financially viable.

5. There should be a maintenance of effort requirement regarding the hospitals' provision of charity care.

6. Given the unique nature of this patient population and given that the county's medical and nursing staff are accustomed to this population, every effort should be made to assure that the county medical staff will be given the same privileges at the private hospitals, and that staffing increases at the private hospitals will be accommodated by former county employees.

7. The private hospitals should assure their seismic safety for the length of the long-term agreement.

Dr. Zaretsky's report provided an estimate of the financial impact of this private sector contracting option. He recommended that the major private hospitals should be made aware that ACMC's ability to maintain its trauma center and to be the provider of last resort to the indigent is contingent upon its ability to maintain its Medi-Cal base, Without this payment base, DSH payments, which heavily subsidize indigent patients, would disappear. Without these subsidies, ACMC would be forced to discontinue its inpatient services and would then contract with private hospitals to provide care to CMSP patients at a level it could afford (e.g., realignment funds plus the current general fund subsidy, which is zero.) The loss of tens of millions of dollars in DSH funds, which heavily subsidize indigent care, would require private providers to incur losses approaching that level from treating these patients.

Dr. Zaretsky estimated that the private hospitals would have to absorb a payment shortfall of $18 million beyond the realignment funds the county could provide. In factoring in the impact of the additional Medi-Cal revenues these hospitals would obtain, Dr. Zaretsky concluded that "it is highly unlikely that the incremental costs to the private hospitals of the new CMSP and Medi-Cal volume would be sufficiently below the total costs estimated here to offset the payment shortfalls to an acceptable extent." He concluded the losses could only be offset by dramatic cuts in service to this population, and an accompanying deterioration in health status.

Immediate Implementation Steps to follow Authorization by Board of Supervisors

Efforts necessary to gear up ACMC to be a full service, competitive hospital should begin immediately after authorization by the Board of Supervisors. Dr. Zaretsky proposed a timetable through the end of the current fiscal year for those activities which address the most urgent needs but do not require major expenditure commitments. **If these implementation recommendations are followed, ACMC should have policies in place by the end of this fiscal year to enhance its competitive position.**

Dr. Zaretsky noted that the urgency with respect to the building project is based on the need to meet potential Office of Statewide Health Planning and Development (OSHPD) concerns regarding modifications to plans submitted in 1994 that will not trigger a new submittal (so that SB 1732 funding eligibility can be protected.)

Activities which are recommended to be completed prior to June 30, 1996 are as follows:

1. *Convene group of ACMC, CBO, and other physicians to identify short-term and long-term actions to expand referral base.*

2. *Develop ground rules for CBO referrals.*

3. *Reassess plans for Highland critical care building.*

4. *Negotiate changes in plans with OSHPD.*

5. *Reassess Local Initiative default procedure.*

6. *Develop plans for reorganizing and streamlining clinic space*

7. *Develop marketing plan for ACMC for Alliance and Blue Cross.*

8. *Develop plans for encouraging county employees to use ACMC and its clinic network*

9. *Implement above plans and procedures commencing July 1, 1996.*

The Task Force unanimously endorsed Dr. Zaretsky's report and its recommendations. This report formed the basis for the substantive discussions of February 26th and the Task Force's recommendations to the Board of Supervisors.

NEXT STEPS - WHERE DO WE GO FROM HERE?

Strategic Planning Process

Now that the work of the Task Force is completed, a transition is taking place into an ongoing strategic planning process for the Alameda County Medical Center. The Services and Delivery Committee of the Task Force is being transformed into the Medical Center's Strategic Planning Committee, with a slightly altered membership. Chief Executive Officer Mike Smart sent out invitation letters in February 1996 to groups which are being asked to nominate a member to serve on the Strategic Planning Committee. The following composition is planned for the new committee which will guide the Medical Center's strategic planning process:

- ◊ Chief Executive Officer, Chair
- ◊ Chief Financial Officer
- ◊ President of the Medical Staff
- ◊ Two (2) Representatives of the Medical Executive Committee
- ◊ One representative from Board of Trustees
- ◊ Chief Operating Officer- Ambulatory Care Services
- ◊ Assistant Administrator for Ancillary and Support Services
- ◊ One union representative
- ◊ One employee selected through an open nomination process
- ◊ One representative of the CBO clinics

- ◊ One Associate Director of Nursing
- ◊ One Consumer from the ACMC Community Advisory Commission

Total Proposed Membership = Thirteen (13) Members

At such time as the new Transitional Governing Body becomes operational, the membership of the ACMC Strategic Planning Committee shall be redefined to incorporate members of the new Commission.

It is envisioned that the overall Strategic Planning Committee will break down into subcommittees dealing with different program areas of the Medical Center. The first meeting of the new Committee will be held jointly with members of the Services and Delivery Committee to ensure a smooth transition; it is expected to be held during the last week of March or first week in April. The first charges to the Strategic Planning Committee will be to:

- Oversee implementation of the tasks identified by the Medical Center Task Force, which include:
  - * Operational changes which are necessary in order to attract, serve, and retain Medi-Cal managed care patients at the Medical Center;
  - * Recommendations from Dr. Zaretsky's report on implementation steps for adoption of the full-service competitive medical center option;
  - * Other priority improvements for the Medical Center contained in the Recommendation Section of this report.
- Coordinate the strategic planning process with the FY 96-97 budget development process, to assure that the budget is consistent with the Medical Center's selected role and market position;
- Develop a strategic plan in draft form within two months that will guide budget decisions and investment plans for the Medical Center; *and*
- Oversee development of a revised plan for Alameda County's SB 1732 capital project, to be submitted to the State of California prior to the end of the current fiscal year.

The Strategic Planning Committee will also play an ongoing role in monitoring and overseeing changes that are being made in the Medical Center. It will report to the Board of Trustees on a quarterly basis.

The work of the Strategic Planning Committee will serve a dual purpose. It will also contribute to the Alameda County Medical Center's preparations for an accreditation review by the Joint Commission on the Accreditation of Health Care Organizations, which is scheduled to take place in November - December 1996. The work of the Task Force and its successor Strategic Planning Committee, will be used to meet the Joint Commission requirements for improving organizational performance; the Commission encourages an emphasis on improving access to care and outcomes. The involvement of a member of the Board of Trustees, Supervisor Chan, in the process will bolster its value in helping the Medical Center through its accreditation.

Action Plan for Preparing to Serve Managed Care Patients

Already, important steps are occurring at the Medical Center to implement the Task Force's recommendations. A consolidated work plan has been developed with responsible persons identified and target dates set, combining the tasks from three work groups at the all-day Task Force work session with Dr. Zaretsky's recommended implementation plan.

Major components of the action plan which has been developed are listed below:

Identification and Follow-up of Patients

- Assign managed care patients of ACMC to a provider and notify providers of patients they have been assigned.
- Develop a "point of contact" for all managed care patients.
- Identify a managed care liaison at all clinic locations and each campus.
- Send everyone a postcard or letter welcoming them and give them both the name of their provider and a managed care contact person.
- Inform ER, Clinic, Registration, Admissions, and Clinical staff of how to identify and acknowledge managed care patients. Reinforce prior trainings.

Public Relations

- Develop a marketing plan for ACMC for both the Local Initiative (Alameda Alliance for Health) and Commercial Plan (Blue Cross.)
- Develop a welcome package: brochure, information, and goodies; host an open house for our managed care patients to meet medical staff; offer them free classes.
- Make better use of free marketing opportunities, e.g., PSA's.
- Develop an attractive marketing piece for managed care population.
- Develop a brochure/letter for outreach to our current AFDC patients to join Alliance and identify the ACMC as their PCP.
- Do a mailing to all current AFDC users.

Medical Record Availability/ Medical Information

- Develop system for access to medical records at the point of service.
- Improve the manual system to transmit medical information - pending automated system

Cosmetic Improvements

- Lobby, outpatient clinics: separate smoking areas; out of sight (not by lobby)
- Paint walls
- Put art on walls
- Improve ongoing cleanliness

Configuration of Services/Enhanced Receptivity of Physical Environment

- Develop plans for reorganizing and streamlining clinic space to remedy confusion and inefficiency of current layout;
- Each MD must have at least two exam rooms during clinic sessions to increase productivity;

- Carry out further consolidation of women's and children's services to implement "one-stop shopping" which can be marketed to the AFDC population.

Operational Improvements

- Prioritize operational improvements for primary care and specialty care clinics.
- Evaluate ACMC's ability to add clinic hours (either evenings or weekends) or more days/week to increase clinic capacity.
- Expand access to Advice Nurse. Translation and Medical Social Services need to be involved.
- Staff preparation at every level -
    - ◊ Phone etiquette/Customer Relations
    - ◊ #1 priority - to hold on to the managed care patient

Billing

- Improve patient billing process by:
    - ◊ batching all clinic charge documents by clinic and ensuring timely processing;
    - ◊ filling in all charge documents

Appointments and Registration

- Establish a separate phone number for managed care patients to bypass current Central Appointments System.
- Set up a parallel appointment system for managed care patients and then patch into MIS in the short run.
- Restructure appointment scheduling system - look at current capacity and assess whether additional capacity needs to be added.
- Consider potential rewards for physician participation, in light of budget cuts. Coordinate with Oak Care.
- Develop internal accessibility standards and a system for scheduling appointments to meet these access criteria, which must meet or exceed State managed care requirements.
- Check with Ambulatory Care for compatibility.
- Designate a specific registration person assigned to Alliance patients at each site.

MIS

- Assess current status - Shared Medical Systems (SMS) upgrade has been delayed until 1997 due to late start-up of project. Develop accelerated implementation dates
- Determine when appointment and registration system will be ready - speed up

Communication with PCP, Clinics, All Providers

- Improve coordination/support between Alliance and Medical Center. It was noted that the first meeting for this ongoing coordination had already happened.
- Improve reporting of results to PCP's within 24 hours.
- Develop groundrules for CBO and county clinic referrals.
- Convene group of ACMC, CBO, and other physicians to identify short-term and long-term actions to expand referral base.

- Facilitate access for patients from outside providers to specialty and inpatient care.

The following steps toward implementing the action plan have taken place to begin accommodating managed care patients assigned to the Medical Center through the Alameda Alliance for Health:

- In preliminary meetings with the Medical staff, it was decided that an interim system needs to be put into place to expedite service to managed care patients. A "Point of Service" program has been approved for implementation:
  - ◊ Alliance patients will be directed to a centralized phone contact.
  - ◊ Staff to address needs such as appointments, telephone advice, and assistance in negotiating the system, will be located in a single area of the hospital, such as a suite or large room.
  - ◊ These staff will tend to all the incoming phone calls and field them on the spot.
  - ◊ The Medical Center is laying the necessary groundwork, securing space and installing phone lines, in preparation for the "Point of Service" program.

- Joni Thomas, Assistant Hospital Administrator, met with the President of the Medical Executive Committee to discuss the need to establish a process to assign the Primary Care Physician (PCP) for Alliance patients. Drs. Wofsy and Jackson were given lead responsibility.
  - ◊ The process for assigning Alliance patients to PCP's is now being developed.
  - ◊ Dr. Ed Clark, Alliance Medical Director attended the March 1996 Medical Executive Committee meeting. Planning will take place to meet the Alliance requirement for tracking services delivered by PCP;
  - ◊ Discussions are being held between the Alliance and department heads for Pediatrics, Ob/Gyn, and Adult Medicine departments to discuss department-specific issues;
  - ◊ A procedure is being designed that will assure that the PCP for each patient is identified within all parts of the patient care system (e.g., registration, follow-up appointments, etc.)

- Joni Thomas and Carol Oakley, Chief Financial Officer, are developing a system to identify Alliance patients at the registration contact point and track their care through the system as services are rendered. The Finance Department is planning to implement the required changes within the registration process.
- A general meeting of the "key" staff leadership involved in these changes is being scheduled for March 1996.
- The major public relations and communications tasks have all been assigned to specific individuals, including the "welcome package," brochure design and development, and patient classes development.

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In addition, work has begun on implementing the recommendations for capital improvements. Dave Kears, HCSA Director, has met with John Rodriguez, Deputy Director of the Department of Health Services, regarding reactivating and modifying Alameda County's SB 1732 proposal. The State was encouraging that the project can move forward in a modified form and alternative strategies for pursuing the project were put on the table.

Consensus today on the future of the Medical Center is vastly improved from the point at which the Task Force was convened in September 1995. While the budget process for the coming fiscal year promises to be painful, there is a better understanding of the mid-term and long range changes which are necessary to assure the Medical Center's survival, and a fresh willingness by all interested parties respond to changes demanded by the environment in which the Medical Center must operate.

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The Task Force has played an invaluable role in bringing diverse interests together to decide upon and commit to a shared vision on the future role of the Alameda County Medical Center. The Task Force is pleased to forward this report the Alameda County Board of Supervisors. By approving its recommendations, the Board of Supervisors can take the next step in making that vision a reality. Each and every member stands ready to assist its implementation. It is crucial that this not be a report that is simply filed and ignored. The time is short, and if we are not successful, the health of our community is at risk.

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APPENDICES.

Appendix 1. Alameda County Medical Center Task Force Participants

Task Force Members

Supervisor Wilma Chan, Chair
Erma Albert, RN, Alameda County Medical Center
Judy Armstrong, Alameda County Medical Center
Harold Brazil, MD, Alameda County Medical Center
Robert Cooper, MD, West Oakland Health Council
Jim Devitt, Alameda County Medical Center
Amalia Egri, Staff to Supervisor Keith Carson
Ron Eisenberg, MD, Alameda County Medical Center
Hussam El-Gohary, MD, Alameda County Medical Center
Rob Feldman, MD, Alameda County Medical Center
Peter Forster, MD, Alameda County Medical Center
Al Groh, Union of American Physicians and Dentists
Dellreitta Guion, Consumer
Jay Harness, MD, Alameda County Medical Center
Doug Hickling, Deputy County Counsel
Arlen Hoh, MD, Alameda County Medical Center
Sandra Holliday, Alameda County Medical Center
Fran Jefferson, SEIU Local 616
Jacqueline Jones, Alameda County Medical Center
Dave Kears, Health Care Services Agency
Veda La Baer, Consumer
Margaret Leong, SEIU Local 535
Charlotte Martinelli, Alameda County CAO's Office
Pamela Martinez, SEIU Local 250
Betty Moose, Alameda County Community Advisory Committee
John Norton, MD, Alameda County Medical Association
Carol Oakley, CFO, Alameda County Medical Center
Claude Organ, MD, Alameda County Medical Center
Arnold Perkins, Alameda County Department of Public Health
Ted Rose, MD, Alameda County Medical Center
Kathy Schnepple, Consumer
Ruth Shane, Alameda County Management Employees Association
Ralph Silber, Alameda Health Consortium
Michael Smart, CEO, Alameda County Medical Center
Joni Thomas, Alameda County Medical Center
Marye Thomas, MD, Department of Behavioral Care
Jonas Williams, MD, Alameda County Medical Center
Gary Young, MD, Alameda County Medical Center

Technical Support Committee
Yolanda Baldovinos, Health Care Services Agency
Vana Chavez, Health Care Services Agency
Natalie Curson, Alameda County Medical Center Information Systems Department
Dorothy Graham, Health Care Services Agency
Jason Lauren, Deputy County Counsel
Charlotte Martinelli, Alameda County CAO's Staff
Carol Oakley, CFO, Alameda County Medical Center
Susan Rosenthal, Staff, Supervisor Wilma Chan

Facilitators
Martin Paley, Center for Common Good
Gordon Firestein, Center for Common Good
Nancy Lee, Center for Common Good
Marty Boyer, Associate, Center for Common Good
Liston Witherill, Associate, Center for Common Good

Outside Presenters
Nina Maruyama, Alameda Alliance for Health
Barbara Kempzcinska, Blue Cross
Jean Nudelman, Kaiser Health System
Barbara Ramsey, MD, Native American Health Center

Consultant
Henry Zaretsky, Ph.D., Henry Zaretsky and Associates

Appendix 2. Data Source Materials Bibliography

These materials are available upon request from the Health Care Services Agency. Please contact Linda Arellano at 667-7994 if you would like a copy of any of these materials.

GENERAL INFORMATION

- **Alameda County Medical Center Licensed Beds**
- **Distribution of Medi-Cal Eligibles & Providers by Region and City Alameda County 1990/91**
- **Alameda Alliance Health Planning Areas, Medicaid Beneficiaries - Map**
- **Profile of Alameda County's Medicaid Beneficiaries**
- **Utilization and Population Characteristics of Alameda County's MEDICAID Patients Receiving Services Via Medicaid Healthcare Funds**
- **Profile and Utilization/Population Characteristics of Alameda County's Indigent Patients**
- **Profile of Alameda County's Indigents Currently Receiving Services Via DSH Medicaid and Indigent Healthcare Funds**
- **Utilization and Population Characteristics of Alameda County's Indigents Currently Receiving Services Via DSH Medicaid and Indigent Healthcare Funds**

DEMOGRAPHICS

- **Alameda County Medical Center - Fairmont Hospital, Patient Sex by Hospital Service, Inpatient Discharges for FY 94-95**
- **Alameda County Medical Center - Highland Hospital, Patient Sex by Hospital Service, Inpatient Discharges for FY 94-95**
- **Alameda County Medical Center - John George Pavilion, Patient Sex by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - Fairmont Hospital, Patient Race by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - Highland Hospital, Patient Race by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - John George Pavilion, Patient Race by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - Fairmont Hospital, Patient Age by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - Highland Hospital, Patient Age by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - John George Pavilion, Patient Age by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - Fairmont Hospital, Patient Language by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - Highland Hospital, Patient Language by Hospital Service, Inpatient Discharges for FY 94-95**

- **Alameda County Medical Center - John George Pavilion, Patient Language by Hospital Service, Inpatient Discharges for FY 94-95**

- **Clinic Billing/Data System - Public Health Clinic Report, Visits by Type of Clinic by Sex, July 1993-June 1994, Location=All**

- **Clinic Billing/Data System - Public Health Clinic Report, Visits by Type of Clinic by Ethnicity, July 1993-June 1994, Location=All**

- **Clinic Billing/Data System - Public Health Clinic Report, Visits by Type of Clinic by Age, July 1993-June 1994, Location=All**

- **Clinic Billing/Data System - Public Health Clinic Report, Visits by Type of Clinic by Language, July 1993-June 1994, Location=All**

- **Clinic Billing/Data System - Public Health Clinic Report, Visits by Type of Clinic by City of Residence by Health Center, July 1993-June 1994**

- **Unduplicated Registered Patients by Health Center, July 1993-June 1994, Account Type by Health Center**

PAYOR MIX

- **Alameda County Medical Center Comparison of Patient Days by Payor Mix for FY 1992/93 through FY 1994/95**

    - **Highland Hospital Payor Mix Analysis FY 1994-95**

UTILIZATION

- **Alameda County Medical Center, FY 1995-96 Budgeted Patient Days Stats By facility, Adjusted Patient Days Projections, YTD As of September 30,1995**

- **Alameda County Medical Center, Special Report for Average Daily Census by Month for Highland and John George, July 1992 - August 1995**

- **Fairmont Hospital, Inpatient Census Statistics by Nurse Station, June 1995 and year to date**

- **Highland General Hospital, Census Summary, for the Month of September 1995 and Year to Date, Emergency Room, Acute Care Clinic, Trauma and Outpatient Visits**

- **Highland General Hospital, Census Summary, for the Month of June 1995 and Year to Date, Emergency Room, Acute Care Clinic, Trauma and Outpatient Visits**

- **Highland General Hospital, Census Summary, for the Month of June 1994 and Year to Date, Emergency Room, Acute Care Clinic, Trauma and Outpatient Visits**

- **Fairmont Ambulatory Care Services Report, Fiscal Year 1995 to 1996**

- **Fairmont Ambulatory Care Services Report, Fiscal Year 1994 to 1995**

- **Ambulatory Care Services, Yearly Clinic Visit Report, Yearly - 7/1/1994 -6/30/95, Run Date: 10/17/95**

FINANCIAL INFORMATION

- **Ambulatory Care Revenue Sources Final Approved FY 95/96--Pie Chart**

- **Ambulatory Care Revenue Sources Final Approved FY 95/96--Bar Graph**

- **Medical Center Revenue Sources Final Approved FY 95/96--Pie Chart**

- **Medical Center Revenue Sources Final Approved FY 95/96--Bar Graph**

COMPARISON WITH OTHER INSTITUTIONS

- **Comparison of Average Daily Census, Acute Care Excluding Newborns, July 1992 - June 1995 by Facility**

    - **Comparison of Average Daily Census, Acute Care Excluding Newborns, July 1994 - June 1995 by Facility**

    - **Comparison of Average Daily Census, Acute Care Excluding Newborns, July 1993 - June 1994 by Facility**

    - **Comparison of Average Daily Census, Acute Care Excluding Newborns, July 1992 - June 1993 by Facility**

- **Alameda County Medical Center, Acute Care Excluding Newborns, Average Daily Census, July 1992 - June 1995**

- **Summit Medical Center, Acute Care Excluding Newborns, Average Daily Census, July 1992 - June 1995**

- **Comparison of Average Daily Census, Newborn Patients, July 1992 - June 1995**

- **Total Births for past three years in six month periods from 7/92 -6/95 by Facility**

- **Alameda County Medical Center, Newborn Patient Average Daily Census, July 1992 - June 1995**

- **Summit Medical Center, Newborn Patient Average Daily Census, July 1992 - June 1995**

- **Comparison of Average Daily Census, Skilled Nursing Facility - Distinct Part July 1993 - June 1995 by Facility**

LOCAL COMPETITIVE FACTORS

- **Summary of Hospital Mergers and Affiliations in Alameda County - As of October 1995**

- **East Bay Medical Network, Alta Bates Corporate Development 6/22/94**

- **East Bay Medical Network (EBMN)**

Appendix 3. Status Report on California's Other County Hospitals and Health Systems.

ALAMEDA COUNTY
HEALTH CARE SERVICES
AGENCY
DAVID J. KEARS, Director

AGENCY FINANCE
1850 Fairway Drive
San Leandro, CA 94577
(510) 667-7995
Fax: (510) 483-6038

MEMORANDUM

TO: ALAMEDA COUNTY MEDICAL CENTER TASK FORCE

FROM: DOROTHY GRAHAM AND SUSAN ROSENTHAL

DATE: 1/28/96

RE: *STATUS REPORT ON CALIFORNIA'S OTHER COUNTY HOSPITALS*

ENCLOSED PLEASE FIND OUR FINAL REPORT ON THE CURRENT STATUS AND FUTURE SURVIVAL OF OTHER COUNTY HOSPITALS THROUGHOUT CALIFORNIA. THIS REPORT WILL BE PRESENTED AT OUR UPCOMING TASK FORCE MEETING ON FEBRUARY 1, 1996.

THIS REPORT REPRESENTS FOUR MONTHS OF INTENSIVE RESEARCH AND INTERVIEWS WITH COUNTY HOSPITAL CEO'S, CFO'S, AND OTHER TOP ADMINISTRATORS IN FOURTEEN OTHER COUNTIES. WE ARE VERY PLEASED TO BE ABLE TO SHARE THE RESULTS OF OUR WORK WITH THE TASK FORCE. AS YOU REVIEW THE REPORT, WE WOULD LIKE TO POINT OUT THREE CAVEATS:

- THIS REPORT WAS PREPARED FOR THE ALAMEDA COUNTY MEDICAL CENTER TASK FORCE TO INVESTIGATE WHAT THE OTHER MAJOR COUNTY HOSPITALS IN CALIFORNIA ARE DOING TO MAKE THEMSELVES COMPETITIVE. WITH THAT PURPOSE, IT DOES NOT CONTAIN A REVIEW OF POSITIVE CHANGES WHICH HAVE BEEN MADE IN OUR OWN ALAMEDA COUNTY MEDICAL CENTER.

- NOTE THAT EVERY CHART DOES NOT INCLUDE INFORMATION ON ALL THE COUNTIES SURVEYED. WE DID NOT RECEIVE COMPLETE INFORMATION ON EACH COUNTY HOSPITAL. EVEN AS WE MAIL OUT THIS REPORT, ADDITIONAL INFORMATION FROM SOME OF THE COUNTIES IS STILL BEING RECEIVED. IF WE HAVE ANY SUPPLEMENTS BY THE THURSDAY TASK FORCE MEETING, OR BY OUR FINAL TASK FORCE MEETING AT THE END OF FEBRUARY, WE WILL BRING SUBSTITUTE PAGES FOR YOU.

- PLEASE ESPECIALLY NOTE THAT THIS IS NOT A SCIENTIFIC SURVEY. IN MANY CASES, DATA MAY NOT HAVE BEEN AVAILABLE FROM THE SAME TIME PERIOD, NOR FROM THE SAME DATA SOURCE FOR EACH COUNTY. HOWEVER, WE DO FEEL THAT THIS REPORT PROVIDES A USEFUL IMPRESSION OF TRENDS AND DIRECTIONS FOR THE HOSPITALS WHICH WE SURVEYED.

STATUS REPORT ON CALIFORNIA'S OTHER COUNTY HOSPITALS

Report to the Alameda County
Medical Center Task Force
Supervisor Wilma Chan, Chair

by

Susan Rosenthal and Dorothy Graham

January 28, 1996

Acknowledgements

The authors would like to gratefully acknowledge the assistance of hospital CEO's and other top county staff in the county hospitals which they interviewed: Contra Costa, Fresno, Kern, Monterey, Riverside, San Bernardino, San Francisco, San Luis Obispo, San Joaquin, San Mateo, Santa Clara, Stanislaus, Sonoma, and Ventura.

These hospital and county staff gave generously of their time and advice, in the hopes that their experiences would be of benefit in our efforts to assure the future of the Alameda County Medical Center.

We thank them for their wisdom and willingness to share invaluable information with us. We hope the information we have gathered will be useful to others as well.

STATUS REPORT ON THE FUTURE OF CALIFORNIA'S COUNTY HOSPITALS

Final Report for the Alameda County Medical Center Task Force
Prepared by Susan Rosenthal and Dorothy Graham

Sunday, January 28, 1996

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Introduction

As we plan for the future of the Alameda County Medical Center, it is important to put ourselves in context of the other seventeen counties within our State which directly operate county hospitals. This report was prepared for the Alameda County Medical Center Task Force to assist in its deliberations. The intent of this report was to investigate what other major county hospitals in California are doing to make themselves competitive and to secure their future. Given this focus, the report purposely does not contain a review of the changes which have been made in our own Alameda County Medical Center. In some of the attached charts, however, statistics from Alameda County are included for purposes of comparison.

Although each county is unique, many common factors are facing public hospitals and health systems in the State as they strive to position themselves for the future:

- With the loss of national health reform, prospects for extending coverage to the uninsured faded;
- The number of uninsured in California is on the rise - increasing those who depend on the County safety net for care;
- Trends of declining hospital occupancy overall have led to empty beds in the private sector, and pressured the private sector to fill those beds with Medi-Cal patients traditionally left to the public sector;
- Private sector hospitals have eroded public hospitals' Disproportionate Share Hospital funding, which has been used by the public sector to support indigent care;
- County budgets have been declining due to the transfer of property taxes to the State, with Counties pulling General Fund dollars out of their hospitals.
- Generally, public hospital's infrastructure is declining, with most currently occupying aging, outmoded facilities.
- Hospital chains such as Columbia/HCA and Sutter Health are moving to take over private non-profits as well as public hospitals.
- The advent of Medi-Cal Managed Care in 12 "expansion counties," which include eleven that operate county hospitals, has accelerated pressure on these hospitals to become competitive in order to retain their market share of Medi-Cal patients.

Counties have generally responded to these factors in one of two ways - most have made a renewed commitment to maintain their hospitals and adapt them to the challenges of the new environment, while a second group have decided to sell, lease or merge their facilities and abandon their role as direct providers of inpatient care.

This report to the Task Force expands upon the initial presentation in November. Information from fourteen counties is now included. This report synthesizes the strategies other counties are using to make themselves viable and competitive in the managed care marketplace. County hospitals are developing plans to make themselves attractive to Medi-Cal and other paying patients and to run more efficiently .

This report includes a discussion of the fiscal picture and competitive situation of other counties, as well as the decision of some counties to close, contract out or merge their facility. The Los Angeles County situation was considered too different and complex to include with this analysis. A separate packet of information on the Los Angeles Medicaid Waiver Demonstration project and related issues is available upon request.

As our November report indicated, not all strategies discussed were used by all counties and not every strategy used elsewhere may be applicable here. Nonetheless, the authors of this report found much that is encouraging and much to be emulated in the other counties we visited or surveyed.

The fourteen counties surveyed are: Contra Costa, Fresno, Kern, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Sonoma, Stanislaus, Ventura.

County Hospitals are at Critical Decision Point

It is clear from our analysis that county hospitals and their related health systems are at a critical juncture in their existence. The counties can essentially be divided into two groups:

- Those which have made a commitment to survival through aggressive strategies to maintain their payor mix and compete under managed care. These counties include:
    - Contra Costa
    - Monterey
    - Riverside
    - San Bernardino
    - San Francisco
    - San Joaquin
    - San Mateo
    - Santa Clara
    - Ventura

The urban county hospitals are largely in the first group, and are all in various stages of rebuilding or replacement projects with SB 1732 funds or other financing mechanisms. It is also noteworthy that all county hospitals in Managed Care Expansion counties, with the exception of Fresno, fall into this first group.

- The second group of counties are those which are attempting to sell or lease their hospitals. This group includes :

    - Fresno
    - San Luis Obispo
    - Sonoma
    - Stanislaus

The counties in the second group are, with the exception of Fresno at 722,000, all smaller rural or suburban counties, with populations of 400,000 or less. These hospitals did not apply for SB 1732 funding and are not being rebuilt or remodeled. Kern County has not yet decided on a strategy. They have a new management team that has only been in place for six months and is trying to develop its basic approach.

Many of the counties which are attempting to assure the survival of their safety net institutions have met with strong private sector opposition, Counties have had to face lawsuits and even in one case a private hospital-sponsored voter initiative in order to preserve their right to serve paying patients and compete under Medi-Cal managed care.

The Basis for Hospitals' Decisions to Rebuild and Become Competitive

The counties which have decided to ensure the survival of their public hospitals appear to share a common philosophy about the importance of the safety net. Many hospital CEO explained this philosophy in the following terms:

- Private hospitals may have empty beds, but they do not have the mission or mandate to serve the indigent population. This mission is unique to the County. County hospitals take everybody - not just selective payor groups. We use excess from one payor group to defray costs of another group. County hospitals serve every patient without discrimination. This is unique to the public sector.
- Private hospitals make decisions based on the market, while public hospitals make decisions based on their mission and use the market to fulfill the mission.
- In the short term, private hospitals may promise you anything, but what will happen later on if the County no longer has its hospital? Private hospitals statewide have been unwilling to make long-term commitments to care for the indigent.
- If the county were to close its hospital, it would mean giving up control and they could not control costs as they do now.
- If the County sets an indigent standard (e.g., federal poverty level), and it is not legally challenge proof, when patients with incomes above the standard show up at private hospitals, the private hospitals may sue the County to cover the costs of their care.
- These counties evaluated the cost-benefit of controlling their own destiny by rebuilding and determined that to allow the market place to do it could cause economic harm to the Country.
- While investing in the county hospital's future has some financial risks, the costs of rebuilding are less risky than for County to be in situation of delegating the delivery of care to the indigent to non-county hospitals.
- The first and most important decision you have to make is whether you are in the business or you are out of it - there is no middle ground as a residual facility that is sustainable over time. Once you make this decision, everything else will flow from it.

The Competitive Environment

County hospitals are facing unprecedented challenges from the changes in the health care marketplace. The mainstay of county funding support to serve the indigent uninsured patients that no other providers want has been SB 855 or Disproportionate Share Hospital (DSH) funding. A hospital's ability to collect DSH funding is based upon its number of inpatient Medi-Cal days. As the private sector aggressively competes for Medi-Cal patients to fill their empty beds, Medi-Cal patients may begin an exodus from the public to the private hospitals. This has two negative consequences for the public hospitals: they lose the direct Medi-Cal revenues for the Medi-Cal patients who have stopped coming, and they lose the DSH funding tied to those inpatient days..

We asked the hospitals we surveyed to what extent private hospitals or other providers are aggressively seeking to take over services they now provide? We also asked whether they were losing Medi-Cal patients to the private sector, and if so, where has the impact been felt the most?

Nine counties provided information in response. In all cases, they responded that the private sector was advertising for Medi-Cal OB patients, in the form of billboards, radio and TV ads and other marketing. In five of these counties, they have experienced a drop in Medi-Cal deliveries as a result, mostly in the 10% range. Three of the nine counties reported decreases in other areas as a result of private sector marketing - two counties in Med/Surg and one in Peds. One county also reported a decline in Medicare patient days as the private sector markets to those patients as well. In response, as these counties are constructing their new hospitals, many of these counties are specifically seeking to improve the competitiveness of their OB services. (see details below).

The private hospitals have shown no such interest in dealing with the indigent population. Their interest has been in taking O.B., or other profitable services. The response back from Counties which have decided to compete is, "we are not going to let you pick and choose. We either survive and do well, or we will not. If we fail, you will have to take all the indigent." The best quote to sum up the competitive environment is on a statue commemorating the issuance of a postage stamp for public hospitals, by Bob Sillen, CEO of Santa Clara Valley Med Center, *"This may be the era of health care competition, but I'll be damned if anybody is competing for my uninsured patients."*

As the private sector seeks to fill empty beds with Medi-Cal patients, public hospitals have developed a broad range of strategies that will enable them to retain their market share and thrive in the new intensely competitive environment.

As this report went to press, a new factor has emerged in the competitive environment, which is the decision announced 1/25/96 by Kaiser Permanente's Northern California Region of a change in how it provides inpatient services. Beginning in Oakland, Kaiser will contract with three private hospitals to provide care for Kaiser members requiring hospitalization. In its announcement, Kaiser gave as one reason the fact that most Northern California hospitals are operating at below 50% capacity. Kaiser's decision will have a major impact on the hospital bed surplus, and may improve the position of public hospitals.

County Competitive Strategies

Those counties which are decided they are in the business to stay have adopted a range of competitive strategies to obtain their goal.

1. Capital Improvements - renovations, rebuilding, remodeling
2. Information System Investments
3. Creating new services and exploiting existing specialized services
4. Operational Improvements
5. Capturing New Clients - expanding the referral base and marketing
6. County Health Plan Development

1. Capital Improvements

Almost all counties with hospitals have embarked on fairly extensive rebuilding, remodeling and renovation projects in the last several years. Building was spurred by the availability of the SB 1732 construction funding from the State.

a. SB 1732 Funding - An Explanation

(Appreciation for information in this section is given to Dr. Henry Zaretsky, Consultant, and to Paul Rosenstiel of E.J. De La Rosa and Company, Inc.)

SB 1732 has been the vehicle for county hospitals throughout California to modernize and become competitive. The funding program was enacted by the Legislature in 1989 as a vehicle to assist disproportionate share hospitals. There were a number of requirements that a hospital must meet in order to be eligible to receive this funding:

1. It must remain a Medi-Cal inpatient contracting hospital through the California Medi-Cal Assistance Commission;
2. It must maintain its disproportionate share hospital status;
3. It must finance the construction project with tax-exempt bonds;
4. It had to meet a deadline for submission of architectural plans to the Office of Statewide Health Planning and Development with a time period that ended on June 30, 1994.

Hospitals that met these requirements received very significant assistance through the Medi-Cal program in financing their capital projects. SB 1732 funding can be used only for building and fixed equipment costs.

The State Medi-Cal program will pay a share of the annual debt service payments for the project, based on the hospital's percentage of Medi-Cal patient days. The State's funding share is calculated based on the average of three years immediately preceding the filing date of the plans. This establishes a percentage of Medi-Cal days which becomes the floor, and your state share cannot go below 90% of that amount. This is the minimum you would get as match - this minimizes risk. From year to year, you will receive a higher percentage if your actual percentage is above the minimum. Therefore, in simple terms, if Medi-Cal inpatient days are 52% of a hospital's total patient days, each year the Medi-Cal program would pay 52% of the debt service on the construction project, with the county having to come up with 48% itself.

On a rebuilding project of $100 million, for example, the annual debt service is in the $8 million range. Under SB 1732, the State would pay $4.2 million (at 52%) and the county would only be required to contribute $3.8 million annually. This program put annual debt service requirements within reach for many county facilities with long overdue capital needs. All county financings have been done through issuance of either Certificates of Participation (COP's) or Lease Revenue Bonds. These instruments are sold to investors. Issuance of COP's or Lease Revenue Bonds does not require voter approval. All that is required is a

majority vote of the County Board of Supervisors approving the COP's or Lease Revenue Bonds.

A county issues COP's or bonds for the entire cost of the new construction project. The SB 1732 funding to pay part of the debt service does not begin until the new facility is ready for use. Therefore, to meet the debt service in the early construction years of the project, each financing included capitalized interest . This means that you borrow more than you need to do the project, and pay off the construction with interest. At the end of construction, a Certificate of Completion is obtained, and SB 1732 reimbursement can commence.

To meet their share of the annual debt service, county hospitals are generally not relying on county general funds in their plans, although it is important to note that the general fund has the ultimate responsibility to pay. In most cases, the hospitals are planning to repay their debt service from new revenues that can be identified as a result of the operation of the new facility.

The attached chart provides details on how each county is planning to meet its annual debt service obligation. Among the methods of repayment are the following:

1. County will pay debt service out of hospital operating budget each year, based on internal savings and increased revenues from more competitive services offered at the new hospital.
2. County is developing deals for commercial use of land adjacent to new hospital.
3. County has gotten agreement from city in which hospital is located to contribute, based on anticipated economic benefit city will derive.
4. County sequesters tax increment funds from property taxes into a reserve fund for capital projects.
5. Savings are anticipated from a consolidation of ambulatory care clinics now being housed in rented space.
6. Savings are anticipated from a consolidation of separately located SNF onto the hospital site.
7. Plan to receive higher reimbursement as a result of moving SNF onto the hospital license.

b. Total Replacement Projects

Of the counties surveyed, seven are building completely new hospitals - Contra Costa, Santa Clara, San Mateo, San Joaquin, Monterey, Riverside, and San Bernardino. An eighth county, Ventura, remodeled their entire hospital in 1987-88, and is now planning a new wing , to be funded by SB 1732 funds to consolidate all primary care specialty care, dietary and lab. A new parking structure is also part of this project. Ventura extensively renovated an offsite primary care clinic last year, known as the Faculty Medical Practice.

In each case of total replacement, the impetus was an old facility that is inadequate and seismically unsafe. The county had to either rebuild or go out of the hospital business. However, the new facility is a major factor in their plans to be competitive. In most cases the rebuilt facility will be smaller than the original and will consolidate services as well.

It is important to note that the new county hospitals are being designed to accommodate the transition to outpatient based care . In most cases, the new design includes an outpatient facility which will consolidate specialty clinics and primary care. They also include same day surgery suites and urgent care centers which will be important factors in competition for

managed care patients. Efforts to go after new markets, such as the Medicare population, are also being factored into the new designs, which may feature services for geriatric patients.

In most cases, the replacement facility is being built adjacent to the old hospital. In a number of cases, however, the new hospital is moving to a different city. In San Bernardino, the County found they could not get an Environmental Impact Report passed on their existing site. They did a demographic origin study of patients and located it closer to their patient base. In Riverside, economics played a factor. By relocating to the town of Moreno Valley, the County was able to secure $75 million, since a study showed the City would gain significant economic benefits from the hospital moving there.

San Bernardino and Riverside Counties are both building hospitals which are larger than their old facilities. In San Bernardino, they are currently running 80% occupancy in a 298 bed hospital. Their new hospital will be 373 beds, with most of the increase accounted for by Psych and their burn unit. They are the regional burn unit for four counties. They are also adding six NICU beds and more OB beds which can swing. Riverside's original project took sizing out to the year 2005, based on rapid projected growth of county population. Building has been designed to allow them to expand beyond their planned 364 beds as needed.

San Joaquin's replacement facility will boast many patient amenities and innovations. One half of the rooms will be private, while the rest will be two-patient rooms. Each room has a full bathroom built to Americans with Disability Act standards, television and phones. The rooms are equipped to do dialysis without the patient having to be moved. At the end of each ward, is built a Respiratory Isolation unit to handle patients with diseases such as tuberculosis. The labor and delivery, Intensive Care, and Med/Surg patient rooms all allow for family members to stay overnight with the patient.

San Bernardino's new facility also features many innovations. It has been designed to withstand an 8.3 earthquake. It is conveniently located right off the freeway offramp. It will offer all private rooms except Pediatrics which has a few doubles. All rooms can be converted into ICU rooms as needed.

Monterey is building a total replacement hospital facility of 414,000 square feet, with 159 beds. In addition, they are constructing a new ambulatory care building, which will provide mostly primary care services for low-income and indigent patients and a 60,000 square foot medical office building. They expect that 40,000 square feet of this will be leased out, to assist in funding the debt service on their construction.

The new hospitals in San Mateo and Contra Costa will be quite a bit smaller than the old hospitals they are replacing. In San Mateo they will consolidate a separate rehab facility, Crystal Springs, into the new building. The county has no OB facility, which has been contracted out to Stanford for thirty years. The County hospital has a good working relationship with the privates. There is a Hospital Consortium in the county where alot of these issues are openly discussed. When the decision to rebuild was made in 1992, there was very little opposition.

The new hospitals in Santa Clara and San Joaquin are smaller, but significant bed capacity will be retained in the old hospital as well. The Santa Clara project, known as the North

Tower Project, replaces their emergency, surgery, radiology and ICU departments with a partial replacement of Med/Surg wards.

With the exception of San Joaquin, which started its replacement project first among counties, many of the new facilities will not be open until 1997 or 1998. According, a number of hospital CEO's explained that they are continuing to invest in either cosmetic changes or major projects in their old facilities, to avoid loss of market share in the meantime. San Bernardino is doing a complete remodeling of the labor and delivery area in old hospital , on the grounds that they cannot afford to lose business.

In Monterey, they have painted their old hospital and done some remodeling, even while moving ahead with construction.

c. Other Capital Investments

Two other counties - Kern and San Francisco- are utilizing SB 1732 funds but not for total replacements. In Kern, the funds have been used to build a new emergency department. In San Francisco, a parking structure is being financed with parking revenue bonds; the County expects the debt service to be partially met by SB 1732.

Several counties have also put major investments into their outpatient clinic network. Stanislaus County purchased an ambulatory care building. They also opened up two new clinics in outlying areas using city redevelopment funds. These clinics have a full range of county health and social services. San Mateo County has opened up five new clinics in the past few years - two are school based and one for homeless teens. Each clinic combines health, public health and mental health services. The largest is a three story clinic in Daly City. The county had no presence in north county prior to this clinic's opening. The physicians associated with Seton Hospital had previously delivered most of the primary care to the Medi-Cal population in this area. The clinic has been very busy since its opening, but there is apparently enough business to go around since the private doctors have not complained.

Santa Clara has a five year ambulatory care plan to build and remodel clinics so they will be able to expand capacity and marketability.

Contra Costa County remodeled its Family Practice Center.

San Francisco has two major building projects and a series of small renovations to San Francisco General Hospital. In addition to the parking garage, a mental health "R facility," which is a medium term, locked facility, is being built with general obligation bonds. The hospital sets aside four million dollars each year to internally fund capital improvement projects. In the last several years the Maternal and Child Service areas have all been completely remodeled. The outpatient and emergency department registration areas have been remodeled and many of the outpatient clinics are in the process of consolidation into one remodeled building.

Counties have also used their own internal resources to fund smaller scale capital improvements. In addition to total replacement projects, most counties have also invested in significant capital projects in the past five years, such as: labor and delivery renovation, emergency room remodel, new ICU's radiology rooms, neonatal intensive care unit, fire and sprinkler systems, cardiac cath lab, CT scanner, Microbiology Lab, Clinical Labs, ADA approved signage, roof replacement, and security improvements such as increased lighting and fencing for hospital parking lots.

2. Information System Investments

Counties have invested resources into their information systems for better management decision making and information management. San Francisco Health Department is investing $25 million citywide ($6 - $8 million of that at SFGH) over a five year period into a system which ties the entire county health delivery system into a fiber optic network with on-line access to medical records. Stanislaus county has upgraded its system in the last three years and has an integrated data base with public health - the client can enter the system at any point.

Monterey has implemented a computerized appointment system using SMS which had a module for appointments. This has resulted in a much improved, while not yet perfected, appointment system for patients.

3. Creating new services and exploiting existing specialized services

In order to manage their patients better and be more efficient many counties are starting new services. Half of the clients that come to the SFGH Emergency Department are put on a fast track - they are seen by a nurse practitioner and not a resident. This has cut waiting times substantially. SFGH has expanded outpatient oncology services, created a Skilled Nursing Facility on campus as well as a med/psych unit. SFGH , in a joint partnership with UCSF, started a primary care clinic that is available only to their managed care clients. Trauma and AIDS units also bring in some insured patients.

Santa Clara County started an urgent care clinic in the Valley Medical Center emergency room and one in the east side of town as well. Paying patients are brought into the system through the trauma center (mostly auto injuries), burn, rehab. services and Workers Comp. The County has recently started a pediatric advice nurse service and will be adding OB and adult medicine to the advice nurse service shortly.

Contra Costa County started an advice nurse program, which is being marketed to other counties. The advice nurse can override clinic waiting lists. A telephone prescription renewal system was started to reduce the utilization of the outpatient clinics for routine matters. The county has a Coordination of Managed Care Pilot Project started in January at two sites. A position of Care Coordinator was created. This person will act as a liaison between providers and their patients to help patients navigate the system. They are operating on a case management model and will work with three providers. The pilot began in January 1996 and will be reevaluated in a year.

Sonoma County started a transitional care unit, a neuro-trauma unit and an occupational health program.

In constructing their replacement hospital, San Joaquin is able to expand their Trauma Center from a Level I to a Level II designation. They are also creating a new stand-along urgent care unit off of their Emergency Room. The new hospital will also have an extensive outpatient surgery center with recovery room.

San Bernardino is building a number of new or expanded services into their replacement hospital. They are adding Pediatric Intensive Care beds. They are adding specialized geriatric services, moving their Rehab service on site from its present off-site location, and adding a new neuro-diagnostic center. They do alot of Rehab business for workers' comp. Their goal is to be the tertiary care alternative to Loma Linda Hospital for everybody in the County.

Ventura County is marketing a number of services where they excel. In terms of marketing current niches - they are working on expanding clients into their outpatient infusion center, and imaging services, including mammogram, which is part of an overall strategy of marketing women's health care. Ventura County is currently investigating starting a home health care program, They plan to use it to save money with their county health plan members, not so much to market it to others, although the potential is there. They are documenting alot of instances where they have needed to purchase home health care and found it to be very expensive.

Ventura County indicated that they have found the chronic disease management area to be one where they excel, but do not market, because the payor mix is poor. In contrast, they prefer to advertise their areas of excellence for services with more third party coverage. One example is their Intensive Care Level III Nursery, where they receive patients from the private hospitals that have only Level II nurseries.

Monterey County has established a freestanding women's center. They brought in a group of bilingual female OB/Gyn's to staff the center. The clinic has a separate advisory board with a group of twenty well-connected women who fund raise for the clinic. It attracts a diverse clientele including middle class insured patients. OB patients are referred to Natividad Medical Center for deliveries.

San Mateo County is working with Stanford to put a county clinic on their campus. Stanford's overhead is higher than the county's due to overhead payments for the medical school so they lose money on outpatients. Major issues to be ironed out are where to hospitalize those clinic patients and which ancillary services are to be utilized. The County also has a mobile clinic van.

4. Operational Improvements

Counties have put thought and resources into operational improvements as they prepare for managed care. The capital improvements will be wasted if clients and resources cannot be efficiently managed. Many of these improvements take an initial financial investment.

Santa Clara has a consulting contract with Mercer to create $20 million dollars worth of savings in efficiencies per year in each of the next three years. Goal is to get costs down and to improve services so that marketability is improved. Santa Clara County has started a Pediatric Urgent Care Clinic that operates seven days a week and has evening hours. All primary care clinic schedules are porous so that people can be fit in as same day appointments. Still have long waiting times at specialty care clinics which they are trying to bring down through dealing with staffing, productivity and facility improvements. Also looking at the teaching program as to how it integrates with the philosophy of managed care. Are also taking a close look and reevaluating how providers are spending their time - on committees? on academics?

San Francisco emphasizes eligibility - qualifying as many people as possible for Medi-Cal. SFGH has taken steps to collapse eligibility, registration and the appointment clerk to one person. They have created and actively monitored productivity standards for their outpatient clinics. Attending physicians are becoming more involved in the management of patient care and in the running of the clinics. Financial incentives were created - a clinic could not participate in the managed care pilot programs unless it met the productivity standards.

SFGH started preparing for managed care three years ago by reducing personnel, mostly through attrition. The outpatient pharmacy was streamlined so that most patients have their prescription within 20 minutes. The organization was flattened through a reduction in administration. In a controversial move, managed care patients were moved to the head of the line for clinic appointments. A special parking lot was designated for managed care and Workers Comp. patients. Although staff has been trained in customer relations, this has not yet made a difference.

Contra Costa - Continuous Quality Improvement teams are working on shortening waiting times for clinic appointments. A focus on continuity of care has been promoted through a stronger case management role for the primary care physician. Two case management positions have just been created as a pilot project. These case managers will act as intermediaries between the patients, the system and the physicians.

San Mateo emphasizes quality assurance . Exit surveys are conducted with all clients. Satisfaction surveys are given to all new clients within 48 hours of first contact. There is a patient advocate for complaints - deals one to one with problems. The county manages indigents as if they were a block grant with incentives to get them into primary care. Waiting times when patients show up for appointments averages one hour - continuously monitored. They have contracted out security and linen service - are looking at other contracts, but don't expect a huge amount. The hospital has implemented skill mix change slowly through attrition and transfer. They employ aggressive UR and discharge planning, and have downsized management staff. There is an emphasis on customer orientation - but not a formal plan. They tried a formal plan in the past - was a failure; now they continuously work on it in staff meetings. Unions have bought into the necessity.

Sonoma has an integrated case management team to ensure proper utilization of hospital services and enhance marketability to managed care organizations. The county has

developed productivity standards and established a Physician's Advisory Council to make the hospital more responsive to physician needs.

Monterey has worked to change the "culture" among providers in order to reduce waiting times. The CEO felt that certain provider groups and faculty were on their schedule, not patients' schedule. Now there is a clear priority to get patients through, In one case, a provider group had to be replaced.

San Bernardino is adding a phone triage system and an automated appointment system. These were significant problem areas in the past. The new triage system must be staffed 24 hours a day, seven days a week. It will take 22 staff to run it, including nurses. They must buy software for the critical path. They are going to attempt to market their phone triage system to private MD's who have not signed up yet.

5. Capturing New Clients: Expanding the Referral Base and Marketing

In Santa Clara county outpatient clinics must admit to VMC; CBO's are strongly encouraged to do so. The hospital competes for private sector patients through Workers Comp. contracts and in the discounted private insurance market. For several years, the county has been working on getting private contracts with insurance companies for specialty services, so that they would be in the network for all services. It was hard to get delegated authority from the BOS to enter into discounted contracts - which was needed to make a deal with case managers or insurers. They are now getting some private pay patients. Loyal graduates from residency programs continue to refer patients. Valley Med Center has become a Category 1 provider for Blue Cross and are included in the Prudent Buyer Plan, which means that they can pick up some clients for primary and acute care.

San Francisco - Doctors have created an IPA which includes UCSF and the county primary care clinics. CBO physicians were reluctant to join because they did not want to be swallowed up by UC. SFGH had a managed care pilot project with Pacific Care. They found that MD's resisted the rules and admitted patients to UC and other hospitals, even though the network hospital was SFGH. Patients also resisted rules - they had been used to seeing specialists without going through their primary care practitioner and wanted to continue that practice.

Stanislaus, Contra Costa and San Mateo - County clinic doctors admit patients to the county hospital for ease of practice - they can do rounds in one hospital.

Sonoma County's hospital helped establish a physician group to work with the hospital to market to health plans and expand insured patient referral base. The hospital started a Marketing Department.

San Joaquin is going after Medicare as a new market - especially Rehab. They developed an extensive plan to market the hospital to community doctors - the county hospital based physicians will take over the care of patients when their patients enter the hospital and not deduct any fees from their capitation rate. These patients are treated by attending physicians, not residents, and are admitted directly to the floor. A Provider Support Department facilitates

inpatient admissions and specialty care. The county is creating a Physician Hospital Organization to facilitate contracts with commercial insurers.

Riverside County is presently doing little in the area of senior care - only 5%- but plans to make significant inroads in this area. The County has an aging population and a shortage of facilities to serve them. They have identified 80 beds within the hospital to transform into a discrete unit of lower level hospital services - these include SNF, Rehab, TIC, and Medi-Cal but not Medicare approved long term care. They are working with a consultant to design this part of their new hospital. They are planning to apply under the Bates long term care pilot project to be one of the five pilot counties statewide.

Riverside County is also in negotiations with Senior Care Action Network (SCAN) which operates a Social/ HMO for seniors. Under the S/HMO, providers receive get 100% of fee for service, vs. the 90% in other Medicare risk programs. They are planning a major marketing effort to double SCAN's enrollment, by working with the County Welfare dept. to enroll people, to add 9,000 members in Riverside.

Riverside is also developing strategies for direct admission of patients from private MD's. They will admit these patients direct to the floors instead of sending them through Emergency Room. They are also trying to make it easier for other hospitals to transfer patients.

San Bernardino is talking to unaligned physicians who do not have hospital privileges and who will need it under managed care. The County will do the inpatient care for those who are not board certified.

Ventura County operates its health plan for county employees and has used marketing of prevention activities to increase their market share from 1/3 to 50% of all county employees. They are also very interested in expanding their workers' comp practice. They have hired two staff to work on this as a special project, and have one clinic designated to serve only their workers comp and county employee business.

An area of concern has been maintaining market share in OB, since this is one of the services in which the private sector universally competes aggressively. Ways of making the OB Service more competitive are being built into replacement projects. For example, at San Joaquin, the labor and delivery rooms include multiple birthing centers. Rooms are all private and each has a full bath, TV, and phones. Rooms also provide for family members to sleep in. San Bernardino is aggressively going after the OB market as well. They reported a drop in OB after Prop 187 passed, with some of their patients choosing to deliver in Arizona and Texas instead.

Monterey County established a decentralized clinic in South Salinas, which is designed to serve employee health patients, military patients, and insured patients. This did create some problems because of equal access issues, but they decided to go ahead anyway.

San Bernardino worked to market its services to county employees. They offer employees an incentive to use the County Medical Center. They have found there are still some limiting factors in ability to attract employees - difficulties in getting through on the phones, mix of MIA and Medi-Cal patients with commercial patients, and concerns about confidentiality. The

County is trying to show employees the link between its economic health and theirs (i.e. job security.) Now they established several distinct clinic operations - one is a teaching clinic where residents work and another is a non teaching clinic that serves the commercial market.

The admissions to the county hospital in San Mateo County are holding steady, however, there is a 10% decline in census due to shortened length of stay. The county believes that they are chosen for the following reasons:

1. Geography - natural selection
2. Established relationships
3. County physicians hospitalize primarily at the county hospital
4. Language capacity - noone else has the capacity, especially in Spanish
5. Diversity

The county just conducted a three month campaign to get patients to identify the county as the PCP when they first enroll in Medi-Cal.

6. County Health Plan Development

Six of the counties surveyed have County Health Plans (county HMO) in various stages of development: Contra Costa and San Mateo (the most developed), San Joaquin, Ventura, Riverside and Monterey. These plans are county HMO's which use county clinics and the county hospital to provide services to their members. The plan in Contra Costa has been in existence for many years and serves county employees, the general public and public welfare recipients. One third of county employees are members because all other plans are more costly to the employee. Indigents are enrolled at the time of service. Forty percent of AFDC recipients are currently enrolled in the plan. The Contra Costa Health Plan will be the basis for the county's local initiative. The plan is also marketed to the general public as a low cost insurance plan with special rates for single parents, young adults and children.

San Mateo is a county organized health system. All Medi-Cal recipients receive their care through the Health Plan of San Mateo since 1988 - which includes everything except long term care. The HPSM is a completely separate legal entity. The County is not at risk. However, when the county was granted County Organized Health Plan (COHP) status through a Federal Waiver, they had to agree to keep an arms length relationship from the Health Plan. Any "profits" made by the Health Plan goes back into the plan and cannot be used by the County to improve services. The county is very proactive in getting enrollees to choose county based services. Eligibility Workers are educated continuously about county services. Incentives are given to private non-profit marketers to enroll Medi-Cal recipients into county based services.

Sonoma County tried to develop a health plan geared to county employees and was not successful. San Joaquin is now developing one to market to its own county employees. This will be a major issue in negotiations this year.

Monterey County has also developed a county employee health plan. They have enrolled 2,000 employees with their dependents, a 36% participation rate. As noted elsewhere, a clinic in South Salinas was built to target county employees, among other insured patients. All hospitalization is at the County hospital.

Riverside County is developing an HMO known as Inter-Valley Health Plan specifically set up for county employees. They will use County facilities and MD's.

Ventura Health Plan was developed to serve county employees, who are given a choice between their health plan and one other. Prior to the last open enrollment, 30% of county employees had joined the county plan; now it is close to 50%. In order to serve health plan members, the County did an extensive renovation project and opened an off-site new primary care clinic one year ago and serves exclusively county employees and workers comp. County employees are also free to use (and some do use) the other six satellite clinics, which also serve Medi-Cal and county indigents.

One of Ventura Health Plan's primary marketing devices is a monthly free health promotional activity, which is open to all county employees, not just plan members. Examples of past activities include cholesterol screening, spine checks, blood typing, dermatology checks, etc. They have found that prevention activities are an excellent marketing tool. Regarding the concern of county employees for confidentiality, Ventura County feels that this is dealt with sufficiently as long as employees have a choice of plans. Many found their 2nd choice (formerly Foundation, now Aetna) unresponsive and switched over to the County.

7. Local Initiative Policies

Policies adopted by the Local Initiative can work to either maintain and expand or cut the patient base of County operated services. Several of the counties we surveyed - Monterey, Ventura, Sonoma, San Luis Obispo - are not Medi-Cal Managed Care Expansion Counties.

Of the nine counties surveyed which are establishing Local Initiatives, most are consciously utilizing their local initiative to strengthen the safety net and county run services.

San Francisco - the local initiative has guaranteed SFGH a contract. The safety net is seen as the providers that serve the indigent as well as Medi-Cal recipients. The LI requires that the CBO's affiliate with a larger IPA in order to get a contract. So far most have affiliated with the IPA based at SFGH.

The guiding principles for development and implementation of the Health Plan of San Joaquin state, "give San Joaquin County Health Care System priority in developing and participating in Medi-Cal Managed care Programs." and "protect the role of safety-net providers in caring for both Medi-Cal recipients and persons with no insurance coverage at all." Theses principles have been operationalized through Local Initiative policies created with the protection of the county hospital in mind:

1. County hospital has the right of first refusal to provide specialized services such as advice nurse, after hours urgent care and lab services.
2. Hospital and clinics are favored in default enrollment. Default has been structured so that preference will go to safety net (county facilities and FQHC's.) Only traditional providers with a very high Medi-Cal percentage - 75% or 80% - would qualify.
3. Hospital will be protected during rate negotiations.

Riverside and San Bernardino Counties have developed a Joint Powers Agreement to operate a combined Local Initiative. They have developed an Indigent Care Pool to be funded out of 5% of the capitation rate. It will be spread amongst contracting hospitals based on their CHIP allocation - the county hospitals qualified for 90% of this cap. The reasoning behind this strategy is that the per diem rate for county hospitals is much higher than private hospitals under fee for service Medi-Cal. They will keep the basic rate and capitation the same for all participating hospitals, but the indigent care pool deals with the inequity in blending the rates.

The philosophy of the San Bernardino and Riverside Health Plan was explained as the county needs to take care of itself first - because they have the legal mandate for Section 17000 and the other institutions do not.

The strategic plan for the Santa Clara County Local Initiative explicitly states that its purpose is to support the safety net. One way this is operationalized is that the LI will admit only to DSH hospitals The county has strong, though not majority representation on the LI Board. They are in the process of developing policies that will support county based services. The county lent the LI $2.2 million in start up costs.

The Politics of Rebuilding

In two counties in the Bay area, the private sector waged a very vigorous campaign to prevent the county from building a new facility. In both cases, the county, after some delay, pursued its building project.

The NAACP filed suit against Contra Costa County's plans to rebuild its facility in Martinez. They claimed that the location of the hospital discriminates against Blacks, Hispanics and Asians, denying them equal access to health services. As a result of the delay caused by the lawsuit, three district hospitals, Los Medanos, Brookside and Mt. Diablo submitted a proposal to provide all inpatient and emergency medical services to all county responsibility patients. Dr. Harry Zaretsky analyzed the options available to the county and set down certain conditions for the acceptance of the proposal made by the three district hospitals. The most crucial of these recommendations were:

1. A Joint Powers Authority be created to govern the three hospital system, the county clinics and the Contra Costa Health Plan.
2. All hospitals be obligated to a 30 year contract for the provision of indigent care.
3. The district hospital should collectively absolve the County of its $25 million obligation to defease the bonds already sold to finance the construction of the new hospital.

The district hospitals did not agree to the conditions set down by the county. The NAACP lawsuit was also dismissed and the Board of Supervisors voted to proceed with the construction of the replacement facility.

Santa Clara County had to revisit its decision to replace its facility several times due to private sector pressure on the Board of Supervisors. In 1992 and 1994 the Board went through an extensive process of data collection, study of alternatives and public forums regarding its

decision to build the North Tower. In 1994, private hospitals offered to consider sharing the County's responsibility for care but in the end they would not guarantee taking the County's obligation under State law. In September 1994 the Board voted to proceed with the project.

County Hospitals' Financial Picture

In our survey, we looked at a number of factors concerning county hospitals' financial status. One issue concerned to what extent counties are still making significant contributions to their hospitals from General Fund and Realignment dollars, and what trends have been noted over the past three years. Of the eleven counties which provided this information, eight still receive a County General Fund contribution, with the highest being San Francisco at $29 million and Santa Clara at $26.7 million; the average General Fund contribution amongst counties receiving this funding is $9.7 million annually. Three county hospitals (Fresno, Sonoma, and Stanislaus) do not receive any county General Fund dollars. These are three of the four counties which are getting out of the hospital business.

Ten receive realignment dollars, but Sonoma as a CMSP County does not. Realignment revenues come to counties from the State and are funded from vehicle license fees and sales tax revenues. Most counties noted a decline in General Fund contributions over the past three years, although in two counties (Santa Clara and San Bernardino), the contribution increased after two years of decline. Realignment funding was steady in most counties, although several reported that the funding had been partially redirected to public health. Net County contribution to the public hospitals ranges from 1.3% (Stanislaus) to 27.7% (San Francisco) of the hospitals' budget, with an average of 14.2% of budget among the nine counties reporting this information.

We also inquired whether the county hospitals had faced a deficit going into their FY 95-96 budget and if so, what were the causes of this budget shortfall?

Deficit in FY 94-95	Yes: 7	No: 3
Deficit in FY 95-96	Yes: 7	No: 4

Deficits reported for FY 95-96 ranged from a low of 3.6% of total hospital budget, to a high of 24% (in one of the hospitals which is planning to close.) The average deficit reported for FY 95-96 was 10.7% of total hospital budget. With the one outlier excluded, the average deficit was 8%.

The reasons most commonly given for shortfalls were as follows:

- Loss of SB 855 funds
- Loss of Realignment funds
- Loss of SB 910 funds
- Inflationary cost increases
- Declining census
- Exhaustion of prior year trust fund revenues

We inquired how the hospitals addressed their shortfalls. Responses were as follows:

- County made up the deficit with the help of SB 855
- Reducing the use of temporary employees
- Reduction in employees through attrition
- Addressed with one time revenues - no major reductions
- Increase in funding from past FQHC claims
- Covered by use of fund balance.
- Use of prior year trust funds
- Increase in county General Fund support.
- Elimination of funded but unfilled positions
- Reductions in professional contracts
- Furloughs
- Layoffs (only reported in two counties)

Finally, we inquired whether the hospitals anticipated any additional mid-year deficits for FY 95-96. None of the hospitals projected any additional shortfalls, beyond the ones addressed at the start of the budget year. One pointed to concerns about implementation of Medi-Cal Transitional Care (TIC) which would move acute patients to a lower reimbursement category.

Hospitals Which are Closing, Being Sold or Merging

Our survey includes four counties which have made decisions or are studying options for sale, transfer of their facilities, or closure of their inpatient services.

These counties have cited a number of factors leading to these decisions:

- Falling hospital census - in San Luis Obispo the hospital has an average daily census of 17, while in Stanislaus the average daily census is 48 to 49; Sonoma County's Community Hospital census averaged 60 in the last fiscal year.
- The hospitals care for only a small load of the uninsured; in Stanislaus the hospital census is less than 10% uninsured.
- These county hospitals are in facilities that are in need of extensive capital investment, but the counties did not pursue SB 1732 funds for a variety of reasons: in San Luis Obispo, it was to be financed through General Obligation bonds which were defeated in a 1992 election (got 50% of the vote) through lobbying by the County Medical Association, while in Stanislaus the County decided it could not afford the debt service.
- Fresno did a fiscal analysis which showed that they would be out of business within three years due to funding cuts. However, there was also a political overlay to the analysis. Executive staff and Board of Trustee members of Community Hospital have alot of political clout. Community Hospital romanced the physicians and Board of Supervisors. The consultant, APM, was also inclined toward the merger recommendation. They did not explore any recommendation to make the County facility competitive.

Each County has pursued a different approach to ending its role as a provider of services. In Sonoma, the County issued an RFP for lease of Community Hospital to a private chain. The finalists were for-profit Columbia/HCA and non-profit Sutter Health, which was selected to lease the hospital. Sutter was selected on the basis that the company would provide more charitable care and has more experience in Northern California. The County is currently finalizing terms of a contract for BOS action on February 9th, and the transfer is expected to take place in March. A Press Democrat poll of Sonoma County voters showed that 81%

wanted the Board to consider other alternatives before moving forward with the proposed lease.

In San Luis Obispo, the County was considering a range of possible options, including closure of their inpatient unit and contracting out to private sector providers, to sale to a private corporation, to formation of a hospital district or authority. An update this month confirmed that the BOS has not yet decided on a course of action, nor do they have a firm timeline for a decision.

In Stanislaus, the County has issued an RFP for many options including transferring their acute patients to a private facility, to a possible takeover by a hospital chain. Three hospitals put in bids to work with the county. One is a small rural hospital district - county will work on a partnership for ambulatory care with them. The other two were the two private hospitals in Modesto. The county is entering negotiations with both entities and has hired a lawyer and negotiator to assist them. Stanislaus County is not yet sure if the bids are serious. Nationally, 50% of merger discussions are not consummated. Neither hospital really understands the indigent program. The hospitals are interested in a capitated rate for the indigents, while the county is thinking about a block grant so that it no longer is at risk. There is a possibility of contracting with both for different patient populations. The outcome should be known in March or April.

In Fresno, the Board of Supervisor's contracted with APM to conduct a strategic planning process. The county's own figures had shown that the county would start running a significant deficit. The final report was presented to the Board on May 5, 1995. The Board wanted to get rid of trauma and indigent losses. Critics have pointed out that the report is seriously flawed in the following ways:

1. Missed the key issue of the transitional costs of a merger, which could range from $30-100 million.
2. Missed the issue of the loss of control of the cost of care for the indigent. If hospital is closed, can you reopen if you don't like the cost of care?
3. Report was done without discussion with key players.
4. Consultants never made a site visit. Hospital is old, but well maintained. Earthquake safety is not an issue.
5. What happens to SB 855 money? What happens to education money if contract out for services? How do you pay for indigent care if these sources of revenue disappear?
6. What happens to trauma and burn?

The report recommended creation of a regional medical network through a consolidation with Community Hospitals of Central California (CHCC). A single, large acute care facility downtown would be created. In the beginning of January, the County entered into a 45-60 day period of negotiations with Community Hospitals. They will try to get money from the State to capitalize the project - $20 million is needed. Transition costs have not yet been discussed. Originally, CHCC talked about a four year transition, where CHCC will do burn and ER and provide for indigent care under contract. This could be financially devastating to the County. County hospital would have to keep up the infrastructure, heating, security, etc. CHCC also does not understand the county responsibility for indigent care and the APM report did not discuss its financing.

Public reaction is very negative to the idea of turning over the public hospital to a private institution. There is a huge public outcry. Unions are leading the campaign, but the reaction is much broader. BOS is being pressured to keep the hospital.

In Fresno County a lot of emphasis was put on the Local Initiative as a way to be competitive under managed care. When the County's LI application was not approved, their plans were upset. The county medical group are all sub-specialists and have no experience with managed care. If county goes into managed care, they have to find some MD's experienced in managed care or the system won't work. The County will not invest any resources until a decision is made on the continued existence of the hospital. If there is a merger, outpatient will be merged as well.

The County has maintained its market share because other providers don't want the patients under the current reimbursement schedule. Private hospitals send Medi-Cal patients to VMC since they are not eligible for DSH.

In at least two of these counties, (Fresno and Sonoma) unions and community groups have qualified initiatives for the March or November 1995 ballot to require that any decisions to sell or transfer the hospital be submitted to the voters before action is taken.

Summary

Several themes emerge from this study. County hospitals have historically been very traditional. Many are now demonstrating a resiliency not usually associated with traditional bureaucratic organizations. Accessibility to primary care is being emphasized as well as a responsiveness to patients and community providers. Counties that have made a decision to maintain their mission to directly provide health services have committed significant resources in time, money and personnel to ensure their viability.

Counties are pursuing a complex array of strategies in order to maintain the strength of the county hospital and county run services. Some of these strategies were developed years ago and luckily fit well into the current market place. Many ideas have been developed more recently as managed care has come to dominate the medical market place and county hospital have to compete in this new arena. Each county has a unique situation; but all are facing a common environment. Hopefully this report on the plans and experience of other counties will spur our own creative thinking as we apply these, and other ideas, to our own situation.

ATTACHMENTS

1. COUNTIES IN CALIFORNIA - WITH PUBLIC HOSPITALS AND PARTICIPATING IN MEDI-CAL MANAGED CARE

COUNTY	OPERATES A COUNTY HOSPITAL?	MEDI-CAL MANAGED CARE TWO-PLAN MODEL OR OTHER MANAGED CARE?	HOSPITAL REBUILDING PROJECTS UNDERWAY WITH SB 1732 FINANCING?	HOSPITAL FOR SALE OR TAKEOVER BY ANOTHER HOSPITAL OR CORPORATION?
ALAMEDA	ALAMEDA COUNTY MEDICAL CENTER	YES -TWO PLAN MODEL	NO	
CONTRA COSTA	MERRITHEW HOSPITAL	YES-TWO-PLAN MODEL	YES	
FRESNO	VALLEY MED CTR. OF FRESNO	YES- TWO- PLAN MODEL	NO	YES-PROPOSED TAKEOVER BY COMMUNITY HOSPITAL
KERN	KERN MED CENTER	YES- TWO PLAN MODEL	YES -not total replacement	
MERCED	MERCED COMMUNITY MED CTR.	NO		
LOS ANGELES	HARBOR/UCLA MED CTR., KING/DREW MED CTR., LAC+USC MED CENTER, OLIVE VIEW/UCLA MED CTR., HIGH DESERT HOSPITAL; RANCHO LOS AMIGOS MED CTR.	YES-TWO PLAN MODEL	YES	
MONTEREY	NATIVIDAD MED CENTER	NO	YES -but not with SB 1732 funds-incligible	
RIVERSIDE	RIVERSIDE GENERAL HOSPITAL	YES - TWO PLAN MODEL	YES	
SAN BERNARDINO	SAN BERNARDINO COUNTY MED CENTER	YES - TWO PLAN MODEL	YES	
SAN FRANCISCO	S.F. COUNTY GENERAL/LAGUNA HONDA	YES-TWO PLAN MODEL	YES-not total replacement	
SAN JOAQUIN	SAN JOAQUIN GENERAL HOSPITAL	YES -TWO PLAN MODEL	YES	
SAN LUIS OBISPO	SAN LUIS OBISPO GENERAL HOSPITAL	NO	NO	YES - Plan to close inpatient and contract with a private hospital.
SAN MATEO	SAN MATEO CO GENERAL/ CRYSTAL SPRINGS REHAB	YES- COUNTY ORGANIZED HEALTH SYSTEM	YES	
SANTA CLARA	SANTA CLARA VALLEY MED CENTER	YES -TWO PLAN MODEL	YES	
SONOMA	COMMUNITY HOSPITAL	NO	NO	YES- Chose Sutter Health Corporation to take over hospital through lease arrangement
STANISLAUS	STANISLAUS MEDICAL CENTER	YES-TWO PLAN MODEL	NO	YES-Issued RFP to private sector Nov. 95 - 3bids received; decision not finalixed
TUOLUMNE	TUOLUMNE GENERAL HOSPITAL	NO	NO	
TULARE	NO	YES - TWO PLAN MODEL	N/A	
VENTURA	VENTURA COUNTY MED CENTER	NO	YES- not total replacement	

2. COUNTY HOSPITAL PAYOR MIXES

COUNTY	% MEDI-CAL	% COUNTY INDIGENT	% MEDICARE	% COMMERCIAL/ COUNTY EMPLOYEE	% SELF-PAY (Not Meeting Indigent Std.)	OTHER
ALAMEDA - HIGHLAND HOSPITAL[1]	58%	17%	16%	3%	4%	2%
FAIRMONT HOSPITAL[2]	84%	2%	12%	1%	1%	0%
CONTRA COSTA	44%	14%	15%	14%- Contra Costa Health Plan 3%-private ins.	9%	4%
FRESNO[3]	46%	13%	13%	11%	17%	0%
KERN	56%	11%	10%	10% - Comm. 2% - Co. Em.	11%	0%
SAN BERNARDINO	60%	20%	5%	10%	5%	0%
SAN FRANCISCO	49%	11%	22%	7%	3%	8%
SAN LUIS OBISPO	50%	30%	12%	8%		
SAN MATEO	28%	14%	25%	5%	-	28% - Mental Health Psych
SANTA CLARA[4]	56%/40%	11%/12%	13%/14%	13%/6%	7%/28%	
SONOMA	46%	?	25%	?	?	29% -Did not break out
STANISLAUS[5]	54%	16%	16%	4%	10%	0%
VENTURA[6]	55%	2%	8%	12% Com/3% emp	17%	3%

ACCH16.PAY / Source: Survey of County Hospitals - Conducted Oct 95- January 96

[1] Based on FY 94-95 Data

[2] Based on FY 94-95 Data

[3] Based on net revenues

[4] Inpatient patient mix/outpatient patient mix

[5] Based on revenues

[6] Based on gross revenues July -Dec '95

3. FINANCIAL FACTS ON OTHER COUNTY HOSPITALS

COUNTY	SIZE OF HOSPITAL BUDGET	AVERAGE DAILY CENSUS	MONTHLY # BIRTHS	FY 95-96 Net County Contribution: Gen. Fund & Realignment and as % of budget	Trends on Net County Contribution	Total County Budget FY 93-94 (most recent available/ Deficit for FY 95-96 if any
ALAMEDA	$167.89 Million	201 acute care excl. newborns plus 115 DP-SNF	153	$0 $25 Mill. Realign *14.9%*	GF decreased $5 million since 94-95; Realign. redirected to ambulatory care	$1.1 Billion $ 73 million 6.8%
CONTRA COSTA	$155 Million	124	113	Left blank	Left Blank	$661 million 93-94 4.5% deficit
FRESNO	$137 Million	189	242	$0 General Fund $16.4 million Realignment *12% of hospital budget*	Realignment steady for past three years	$723 million 93-94 $0
KERN	$110 Million	167 (excludes Newborn)	335	$4.9 M Gen. Fund 8.0 M Realignment 12.9 M total *11.7% of hospital bud.*	Decreasing in both areas	$663 million 93-94 2% deficit
SAN BERNARDINO	$128 Million plus mental health	220	150	$4 M General Fund $16 M Realignment $20 M total *15.6% of hosp. bud.*	No General Fund fixed in FY 93-4 and FY 94-5; increased to $4 million in FY 95-6	$1.24 billion 93-94 2.4% deficit
SAN FRANCISCO	$289 Million	289	145	$29 M General Fund $51 M Realignment $80 M total *27.7% of hosp. bud*	GF decreasing over 3 years	$3.2 Billion - 93-94 (Combines City and County of S.F>) 3.5% deficit
SAN LUIS OBISPO	$25 million	17	75-80	$6 M Gen Fund $ 0 Realignment - *24% of hosp. bud.*	Gen. Fund about same; Realignment given to public health	$174 million - 93-94 $0
SAN JOAQUIN	$ 95 Million	137	170	$2.1 million *2.2$ of hosp. bud.*	declining - moneys redirected to public health	$486 million 6% deficit - county has lost $124 M over past 5 yrs. due to state budget -average $25 Million per year.
SAN MATEO	$66.3 Million	70 124- SNF Crystal Springs	Contracted out to Stanford/Packard	$1.3 M Gen Fund $ 11 million Realignment	General Fund declining; Realignment stable	$455 Million 93/94 Left blank

3. FINANCIAL FACTS ON OTHER COUNTY HOSPITALS

COUNTY	SIZE OF HOSPITAL BUDGET	AVERAGE DAILY CENSUS	MONTHLY # BIRTHS	FY 95-96 Net County Contribution: Gen. Fund & Realignment and as % of budget	Trends on Net County Contribution	Total County Budget FY 93-94 (most recent available/ Deficit for FY 95-96 if any
SANTA CLARA	$304.7 Million	272	252	$26.7 M Gen Fund 13.2 M Realignment 9.9 M Prior year trust fund	Gen fund declined for 2 yrs., now increased; Realignment stable	$1.15 Billion 93/94 $0 deficit but for FY 96-97 facing a $25-30 million deficit
STANISLAUS	$44.9 Million	48	Contracted out	$0 Gen Fund $577,000 Realignment *1.3% of hosp. bud.*	Stable	$348 Million 93/94 1.5% 93/94
SONOMA	$60 Million	57 acute care 12 Transitional Care unit patients	189	$0 Gen Fund $0 Realignment	No GF for 5 yrs. They are a CMSP County and most realignment goes back to state to pay for CMSP	$328 Million 93/94
VENTURA	$93.5 Million	91	200	$3.9 M Gen Fund $9.5 M Realignment $13.4 M Total *14.3% of hosp. bud.*	GF declined for two years; realignment stable	$171 Million 93/94 8.2% 95/96

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4. COUNTY INDIGENT STANDARDS

COUNTY	*COUNTY INDIGENT STANDARD*
Alameda	200% of federal poverty level - ability to pay plan with those up to 100% poverty having a 0% obligation and a sliding fee scale up to 200% poverty.
Contra Costa County	Same as federal poverty level
Fresno County	150% of federal poverty level
San Bernardino	Same as Medi-Cal AFDC, county and legal residence
San Francisco	200% of federal poverty level
San Mateo	200% of federal poverty level
Santa Clara	200% of federal poverty level; for outpatient care there is an ability to pay plan with those up to 100% of poverty having a 0% obligation, and a sliding fee scale up to 200% of poverty. For inpatient care those up to 200% poverty have 0% obligation.
Sonoma	CMSP COUNTY - Uses Medi-Cal standard
Ventura	Individual cannot earn more than $688 per month to be qualified under the MIA program

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5. TEACHING PROGRAMS AT COUNTY HOSPITALS

COUNTY	TEACHING PROGRAM?	# OF INTERNS/ RESIDENTS	AVERAGE DAILY CENSUS/ AVERAGE # BIRTHS PER MONTH
Alameda County Med Center	Yes	140	201 153
Contra Costa - Merrithew	Yes	29	124 113
Fresno-Valley Med Ctr.-	Yes	203	189 242
Kern Med Center	Yes	97	167 335
San Bernardino County Med. Ctr.	Yes	80	220 150
San Francisco General Hospital	Yes	252	289 145
San Luis Obispo General	No	0	17 75
San Mateo Co. General	Yes	10-Psych only	70 (30 are Psych) 0
Santa Clara-Valley Med Ctr.	Yes	157	272 252
Sonoma -Community Hospital	Yes	39 - FP	69 189
Stanislaus Medical Center	Yes	27 FP & 2 Surgery	48 0
Ventura County Med Center	Yes	39 + 4 fellows	91 200

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6. COUNTY HOSPITAL REBUILDING PROJECTS WITH SB 1732 FUNDING

COUNTY HOSPITAL	DATE CONSTRUCTION STARTED	SCHED. COMPLETION DATE	BEDS IN NEW FACILITY VS. OLD FACILITY	SQUARE FOOTAGE	TOTAL COST AND ANNUAL DEBT SERVICE	BUILT AT SAME SITE OR DIFFERENT?	FUNDED WITH SB1732 FUNDS? % STATE MATCH	SOURCE OF COUNTY SHARE
SAN BERNARDINO	1994 - TOTAL REPLACEMENT	1ST QUARTER 1998	New: 373 Old: 298	980,000	$438 MILLION INCLUDING FREEWAY OFF RAMPS/	MOVING FROM SAN BERNARDINO TO COLTON - 8 MILES AWAY	YES/	County issued Certificates of Participation . Debt payment will start in 2001. Paid for early years of construction with capitalized interest. Borrowed more than project cost - paid off construction with interest. Also County sequesters tax increment funds from property taxes into a reserve fund for capital projects - plan this out years in advance. When several existing debts are retired, moneys budgeted for those get transferred over to new project.
MONTEREY	1995 - TOTAL REPLACE-MENT	1997	New= 159 total (89 acute, 48 DP SNF, 22 MH) Old : 211 licensed	414,000 sq. ft. plus 60,000 sq. ft. office building	$90 MILLION TOTAL COST $5.2 m Annual Debt Service	NEW CONSTRUCTION IS ADJACENT	NO- not eligible -	County went directly to Wall Street for COP's. Monterey dropped out of CMAC contract with State so not eligible for SB 1732. Using cost-based Medi-Cal to finance.
RIVERSIDE	1995 - TOTAL REPLACE-MENT	1997	364	520,000 sq.ft.	$150 MILLION FOR BUILDING PLUS $22-25 M FOR EQUIPMENT/$20 million annual debt service	NO- MOVING FROM RIVERSIDE TO MORENO VALLEY	YES/	Project is financed through Lease Revenue Bonds - went to market all at once to .Voter approval not required. Debt service will be partially financed by tax increment funds from City of Moreno Valley to provide $75 million in return for expected economic benefits to city of hospital locating there, Also developing deals for commercial use of land adjacent to new hospital - private development of land will help support debt service. County has a capitalized interest fund to fund the debt service until new hospital opens.
SAN JOAQUIN	OCT. 93 - total replacement but some beds retained at old facility- not enough debt service capacity	Feb. 96	97 beds new hospital 212 old hospital, of which 100-120 will be retained.	246,000 sq.ft. main hospital 23,000 sq ft. central plant, loading dock, link	$106 MILLION COP'S, INCLUDING $68 MILLION CONSTRUCTION, $23 M FINANCING COSTS, $15 M OTHER DIRECT COSTS (A/E etc.) $8.7 Annual debt service	Yes-adjacent	YES/ 50% STATE MATCH	County issued Certificates of Participation. Debt service to be covered through earned revenues - paid for out of hospital operating budget each year. Capitalized interest fund has paid full debt service during construction.

6. COUNTY HOSPITAL REBUILDING PROJECTS WITH SB 1732 FUNDING

COUNTY HOSPITAL	DATE CONSTRUCTION STARTED	SCHED. COMPLETION DATE	BEDS IN NEW FACILITY VS. OLD FACILITY	SQUARE FOOTAGE	TOTAL COST AND ANNUAL DEBT SERVICE	BUILT AT SAME SITE OR DIFFERENT?	FUNDED WITH SB1732 FUNDS? % STATE MATCH	SOURCE OF COUNTY SHARE
CONTRA COSTA	MAY 95	June 97	144 in new facility; 179 licensed beds in old facility	??	$81 MILLION/	In Martinez	YES/	County Issued Certificates of Participation. Financing documents permit issuance of additional bonds for future improvements. There was full funding of capitalized interest for six years - helped them deal with delays in construction. Funded through: 1) Internal Savings at Hospital 2) County pledged to set aside $3.5 million of SB 855 revenues as a contingency.
SANTA CLARA	9/94-North Tower	7/98	New facility provides 154 beds - also upgrades surgical suites and diagnostic imaging. Old= 383 available; will retain beds at old facility with an overall net reduction of 86 beds.	315,000 sq. ft	$193 million/$20 million annual debt service	same site	YES/	Internal savings at hospital A portion of the bonds were issued as variable rate bonds in hopes that it would keep debt service costs down.
VENTURA	-Some demolition begun- decision to authorize Certificates of Participation Nov. 94	??	NA- project is for ambulatory care center and parking garage, as well as replacement for IP lab and dietary	Project is to consolidate outpatient services now in leased space in one location	$51 million	YES -located behind Ventura Co. Medical Center	YES/ 51% state match	1) Hospital revenues 2) Savings generated from the Consolidation. They have conducted a financial analysis that shows that the annual debt service will be less than the ongoing costs of renting space for their ambulatory care clinics. Prior major construction projects: new OP facility for County Health Plan employees completed last year; inpatient side major renovation project in 87-88; all financed out of hospital operating budget.
SAN MATEO	1994	4/99	227 new - old had 270 beds	Project will have 268,000 sq. ft. of new space and 88,212 sq. ft. of remodeled space.	$94.7 million $8.8 million /year debt service	yes- will consolidate Crystal Springs Rehab at main campus	Yes	County issued Lease Revenue Bonds Paying for new hospital primarily through consolidation of Crystal Springs and the County Hospital onto one site. Lewin studied the consolidation - will save on administration, staffing and transportation.. Also they plan to receive improved reimbursement through qualifying for higher distinct part SNF rates from Medi-Cal by moving Crystal Springs onto the hospital license, and cost-based capital reimbursement from Medicare for the psych facilities.

Appendix 4. Evaluation of Options for the Future of the Alameda County Medical Center, by Dr. Henry Zaretsky

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EVALUATION OF OPTIONS FOR THE FUTURE OF ALAMEDA COUNTY MEDICAL CENTER

February 16, 1996

FOR PRESENTATION TO
THE ALAMEDA COUNTY MEDICAL CENTER TASK FORCE

Prepared under contract to the County of Alameda, Purchase Order 470-0-7203-00.

EVALUATION OF OPTIONS FOR THE FUTURE OF

ALAMEDA COUNTY MEDICAL CENTER

I. INTRODUCTION AND SUMMARY

A. SCOPE

This study assesses three major models for the future role of Alameda County Medical Center (ACMC) over the intermediate term (i.e., the next five years). The three alternative models are as follows:

(1) ACMC as a "treat and transfer" facility, where the Highland campus hospital would maintain its trauma center designation and largely restrict its inpatient services to trauma and emergency patients. These patients would be transferred to other hospitals upon stabilization. County-obligation patients (County Medical Services Program -- CMSP) who are not emergency admissions would be treated in private hospitals under contract with the County;

(2) ACMC as a treat and transfer facility and as the CMSP hospital. Non-CMSP patients who are not emergency patients would in general be treated in other hospitals. ACMC's payor sources would primarily be CMSP and private and public sponsors of trauma/emergency patients admitted to ACMC; and

(3) ACMC maintaining its current role as a trauma center and the major CMSP provider, as well as a major Medi-Cal provider and source of care for patients of all payor sponsorships.

As part of the evaluation of the above alternatives, the study also addresses mechanisms for coordinating efforts with private hospitals, to minimize risks faced by both sectors of the Alameda County health-care community, and sets forth conditions for contracting with private hospitals.

Given existing payment mechanisms, where a major portion of state and federal funds used to subsidize county-indigent patients is derived through the Medi-Cal program in the form of disproportionate-share payments, it appears that the only feasible alternative is for ACMC to continue to be a high-volume Medi-Cal provider. Given the movement to Medi-Cal managed care and competitive pressures in general, to maintain its Medi-Cal patient base will require ACMC to take initiatives (capital investments and programmatic changes) to be a competitive hospital. Failure to do so would result in Alameda County

being unable to support its Section 17000 obligation without substantial general fund expenditures, either directly through operating its own hospital or indirectly through private-sector contracting.

B. THE ENVIRONMENT

ACMC, and many other county-operated health systems, are faced with a set of nearly bewildering pressures and challenges. Its major funding sources are shrinking. County general fund revenues are no longer a predictable source of funds. ACMC's ability to provide necessary care to unsponsored, county-indigent patients is dependent on its ability to draw a sufficient number of Medi-Cal patients. That ability is severely threatened by competition from private hospitals with increasing excess capacity. While county-hospital funding may be less secure, inevitable cuts in overall Medicaid funding, without establishment of a national health insurance program, will lead to an expansion in the number of county-indigent patients. The ability to successfully compete for Medi-Cal patients will in all likelihood require capital investments on the part of ACMC so that its facilities and services will attract Medi-Cal patients with private-sector choices. If ACMC is unsuccessful in its efforts to protect its funding sources, it is likely the County will not have sufficient resources to meet its indigent-care responsibilities through private-sector contracting. This shortfall in resources will largely be the result of the loss of ACMC's disproportionate-share (DSH) funds of approximately $30 million in the current fiscal year and an estimated $15 million in the coming fiscal year. These funds are not transferrable to other hospitals. (To qualify for DSH status requires high Medi-Cal and/or unsponsored patient loads, and there is an approximately two-year lag between achieving sufficient patient volume and attaining qualification.) Should ACMC cease to operate as a general-acute hospital, there will be a major tug-of-war between the County's indigent-care obligation and the private hospitals' abilities and willingness to accommodate large numbers of these patients without payment.

C. FINDINGS AND RECOMMENDATIONS

1. Treat and Transfer Facility

Under this scenario, ACMC would only be a trauma/emergency hospital. Once patients are stabilized, they would be transferred to other hospitals. Outpatient services would continue to be provided at both campuses. All inpatient services at the Fairmont campus would be discontinued. All inpatient services provided at either campus to CMSP patients who are not trauma/emergency or have been stabilized would be provided at other hospitals under contract. In addition, other county-obligation patients, such as jail patients, will have to be accommodated in private facilities.

Because of the low volume associated with this type of facility, its practicality is doubtful. To be a trauma center, a hospital must provide a fairly comprehensive array of inpatient services, and have substantial back-up personnel and facilities. If volume falls between 38 and 86 percent (a midpoint of 62 percent), as projected here, an adequate patient

base to support a full-service hospital would not exist. In general, hospitals of substantially less than 200 beds in urban areas do not make economic sense. Where geographic access is not a primary constraint, a population base is best served by fewer, and larger, hospitals, for both economic and quality reasons.

In addition to the problem of appropriate size is the loss of substantial DSH payments, which are tied to Medi-Cal patient days. Given that DSH revenue is vital for the support of CMSP, such losses would have to be offset by substantial county general fund appropriations to enable the County to meet its Section 17000 obligation through contracting with private hospitals. All non-trauma/emergency CMSP would have to be contracted to the private sector. With projected DSH losses of $12 million to $28 million in 1995-96, and $6 million to $14 million in 1996-97, private hospitals would be required to incur aggregate losses which could approach a similar magnitude, and which would be only partially offset by profits from receiving ACMC's former Medi-Cal patients.

Another ramification of this model is the loss of the ACMC teaching program, with its associated Medicare direct and indirect graduate medical education subsidies. According to a recent study, the teaching program earned surpluses of $3.3 million in 1994-95.

2. Trauma Center and a CMSP Hospital

Under this scenario, ACMC would remain a trauma center, treating all trauma patients, regardless of payor source, and be the primary hospital provider for CMSP patients. CMSP patients would be treated regardless of admission status. Non-CMSP patients, however, would only be treated if they were trauma patients, and once stabilized, transferred to other hospitals.

The implications of this scenario are similar to those pertaining to the treat and transfer model, with one exception. CMSP patients would continue to be treated at ACMC, rather than contracted to the private sector. The loss of virtually all DSH revenue, however, would have to be offset by considerable general fund contributions, nearly $30 million in the current year. DSH losses are projected at the higher level under the treat and transfer model since Medi-Cal patient days, which drive DSH payments, would only derive from trauma patients.

3. A Competitive Full Service Hospital

Under this scenario, ACMC would maintain its current payor base and take initiatives necessary to maintain that base through the remainder of this decade, and beyond. Given the movement of formerly inpatient services to the outpatient setting and the implementation of Medi-Cal managed care, private providers who, in the past, did not view Medi-Cal as a desired payor source, are increasingly competing for this market segment.

At this time, ACMC should expect to have to compete to retain its Medi-Cal patient base in the mandatory aid categories (the AFDC-related groups which will be required to

enroll in a managed-care plan), a large portion of which is obstetrics-related. ACMC should capitalize on its competitive advantages in terms of a committed medical and support staff accustomed to dealing with hard-to-manage indigent populations, its considerable capabilities due to its extensive teaching program, its dependability at a time when the desirability of Medi-Cal patients to many private providers may be only a fad, and its integrated health system involving a network of county-operated and private clinics linked to ACMC.

It should be noted that Fairmont, given its orientation and lack of competition, at this time appears to be insulated from the type of competition discussed here.

Capital Investments

ACMC should consider reasonable efforts to improve its plant and equipment in a cost-effective manner over the next three-to-five years. The main Highland building, which houses the inpatient facilities, was completed in 1970 and should be adequate to meet the 2008 seismic-safety threshold. The inpatient facilities are generally adequate. There appear to be four major problems on the entire campus: (1) the emergency department is in need of major renovation; (2) the surgery facilities (in- and out-patient) are inadequate; (3) outpatient services are cramped in some areas and spread-out among several buildings in a confusing manner; and (4) parking space is inadequate.

These problems have been recognized in the capital plan adopted by ACMC, which includes construction of a parking structure and of an eight-story critical care building. The latter is to include, in addition to emergency/trauma and surgical facilities, intensive care beds and an imaging center. Architectural plans for the critical care building were filed with OSHPD in time to qualify for financial assistance under SB 1732. The total cost of this project was estimated to be approximately $90 million. Since the plans incorporated only shelled space for a portion of the building (which does not qualify for SB 1732), approximately $60 million in planned capital expenditures would qualify for SB 1732 assistance. Thus, assuming ACMC's Medi-Cal patient-days percentage is 50 percent, SB 1732 will yield $30 million in subsidies.

On the full $90 million project, annual debt-service payments (30 years at 6 percent interest) would be $6.5 million, with $2.2 million in SB 1732 subsidies, for a net county contribution of $4.3 million. If the project could be completed for $60 million, for example by eliminating the shelled floors and those earmarked for ICU and radiology, SB 1732 subsidies of $2.2 million might remain, but the net county contribution would drop to $2.2 million (on a total debt-service payment of $4.4 million).

It appears that to be able to retain a substantial portion of Medi-Cal patient days associated with managed-care enrollees, a significant portion of the construction discussed here will be necessary. These capital-investment decisions will not bear fruit overnight. In the meantime (i.e., until the projects are available for patient use), ACMC will have to fully rely on its other, considerable attributes and attempt to make cosmetic appearance changes and

minor renovations in the existing buildings as appropriate.

Non-Capital-Intensive Measures

Several measures not involving major capital investments are worthy of consideration. They mainly revolve around ACMC capitalizing on its major attributes.

ACMC has more experience in providing care to Alameda County's indigent residents than any other provider. The medical staff, nursing staff and social-services personnel are familiar with the indigent population's unique needs. Private-sector providers do not have this experience and many will find the adjustment difficult, not worth the effort, or impossible. Medical, cultural and linguistic characteristics of this population can best be accommodated by the ACMC staff resources.

ACMC has the potential to form the nucleus of an integrated health delivery system, including long-term-care facilities (Fairmont), mental-health facilities (John George Pavilion), public-health clinics, a network of county-operated and private-non-profit community clinics (community-based organizations [CBOs]), and extensive specialty resources through its teaching program. This system should provide the base to enable the necessary continuity of care and control mechanisms to be a successful health system. To take full advantage of this potential requires investments in necessary information systems to enable and coordinate the flow of data on individual patients and the medical care process among the various facilities and services.

Coordination among these components in ACMC's best interests requires at a minimum that the first choice for hospital and medical specialty referrals on the part of all affiliated clinics is ACMC. Unless there is a distance problem, or a clinic is located adjacent to another hospital, or ACMC does not have the required services (e.g., pediatrics, cardiovascular surgery), all clinics, including CBOs, should be required to refer within the ACMC system (i.e., hospital and specialty clinics). For such coordination to work in the patient's best interests requires the ability of ACMC's programs to accommodate the referring clinics through timely appointment scheduling.. Physicians representing ACMC, CBOs and other community physicians should be brought together to identify improvements needed at ACMC to facilitate establishment of an expanded referral base.

Reconfiguring some of the clinics to be more "patient friendly" could enhance ACMC's marketability. For example, obstetrics, gynecology and pediatrics clinics could be placed in close proximity and scheduling could be coordinated, to enable "one-stop" shopping on the part of mothers and children.

A mechanism being implemented in other public hospitals is establishment of two tracks for patient care, one for insured and Medi-Cal patients, and another for CMSP, since the latter are not being enticed by private-sector providers. The feasibility of such a two-track system should be explored. While it may be controversial, to the extent it contributes to the

financial viability of ACMC, it improves the latter's ability to maintain access for county-obligation patients.

The teaching program provides an opportunity for ACMC to enhance its reputation in various medical specialties, and to enhance its private patient base. For example, in cooperation with private hospitals, ACMC could develop certain "Centers of Excellence" (i.e., specific illnesses for which ACMC would have a regional reputation). One area for such a center could be disease management of cancer patients. Another area could be workplace injuries.

Efforts should be made to encourage county employees to use ACMC and its affiliated physicians through financial incentives, in terms of reduced health-insurance premiums, deductibles or coinsurance.

Another obvious mechanism to retain Medi-Cal managed-care patients is through the Local Initiative, in which ACMC, as the major DSH hospital in Alameda County, is the nucleus. Enrollees should be encouraged to select primary care providers (i.e., county clinics and CBOs) affiliated with ACMC. If they are unable to make a selection, they should be defaulted into the ACMC network.

Finally, consideration should be given to enlisting the support of the private hospitals in two regards -- protecting ACMC's Medi-Cal patient base and coordinating programs with ACMC.

The major private hospitals should be made aware that ACMC's ability to maintain its trauma center and to be the provider of last resort is contingent on its ability to maintain its Medi-Cal patient base. Without this payment base, DSH payments, which heavily subsidize ACMC's CMSP patients, will disappear. Without these subsidies, ACMC will be forced to discontinue its inpatient services at Highland. The County would then contract with private hospitals to provide care to CMSP patients at the level it could afford (e.g., realignment funds plus the current general fund contribution, which is zero!). The loss of tens of millions of dollars in DSH funds, which heavily subsidize the CMSP program, will require private providers to incur major losses from treating these patients. Such losses will only be ameliorated through dramatic cuts in service to this population, and accompanying deterioration in health status, which would be politically intolerable.

To protect the private hospitals from this scenario, mechanisms should be explored through, for example, Local Initiative policies to protect ACMC's Medi-Cal patient base.

In addition, under SB 697 (Torres), enacted in 1994, not-for-profit hospitals, either alone or through other organizational arrangements, are required to conduct a community needs assessment and to develop a community benefits plan. ACMC should initiate a process to enable all local hospitals to work together in this effort.

4. Coordinating Efforts with Private Hospitals

It appears there are only two feasible options: maintain ACMC as an institution capable of attracting a sufficient Medi-Cal revenue base, and related DSH subsidies, or cease inpatient operations altogether, in favor of private-sector contracting for county-obligation patients. Should the Board of Supervisors decide to close ACMC as an inpatient facility, and contract with private hospitals to fulfill its Section 17000 obligations, it should be guided by a policy based on the following:

1. The private hospitals should make a legally-binding, long-term (i.e., 25-30 years) commitment to provide mainstream care to all patients in need of such care.

2. The hospitals' track records in treating the indigent (especially Medi-Cal) should be established.

3. The general-fund exposure to the county should be reasonable and predictable. (It is currently zero.)

4. The private hospitals should coordinate and integrate services among themselves in their community's best interests, and should be financially viable.

5. There should be a maintenance of effort requirement regarding the hospitals' provision of charity care.

7. Given the unique nature of this patient population and given that the county's medical and nursing staff are accustomed to this population, maximum effort should be made to assure that the county medical staff will be given the same privileges at the private hospitals and that staffing increases at the private hospitals will be accommodated by former county employees.

8. The private hospitals should assure their seismic safety for the length of the long-term agreement.

5. Immediate Implementation Steps

Assuming Board authorization to proceed with the direction recommended here, several steps should be taken immediately to address urgent concerns that do not require substantial funding commitments (e.g., working with ACMC, CBO and other physicians to enhance referral potential and to improve ACMC operations to encourage referrals; to reassess the critical care building plans; and to streamline and reconfigure a portion of the clinic space to be more "patient friendly"). These immediate steps should be completed by July 1996.

II. SCOPE OF STUDY

A. Models

This study examines three major models for the future role of Alameda County Medical Center (ACMC) over the intermediate term (i.e., the next five years). The three alternative models are as follows:

(1) ACMC as a "treat and transfer" facility, where the Highland campus hospital would maintain its trauma center designation and largely restrict its inpatient services to trauma and emergency patients. These patients would be transferred to other hospitals upon stabilization. County-obligation patients (County Medical Services Program -- CMSP) who are not emergency admissions would be treated in private hospitals under contract with the County;

(2) ACMC as a treat and transfer facility and as the CMSP hospital. Non-CMSP patients who are not emergency patients would in general be treated in other hospitals. ACMC's payor sources would primarily be CMSP and private and public sponsors of trauma/emergency patients admitted to ACMC; and

(3) ACMC maintaining its current role as a trauma center and the major CMSP provider, as well as a major Medi-Cal provider and source of care for patients of all payor sponsorships.

As part of the evaluation of the above alternatives, the study also addresses mechanisms for coordinating efforts with private hospitals, to minimize risks faced by both sectors of the Alameda County health-care community, and sets forth conditions for contracting with private hospitals.

B. Approach

The three models are evaluated in terms of their likely impact on volume, revenue, expenses (operating and capital), and service capability. The primary data source is ACMC data on volume and charges for calendar-year 1995, broken out according to service, payor source and admission source (e.g., trauma, emergency). Because the data were generated in early January 1996, the data pertaining to services provided in late 1995 may be incomplete. This should not create a problem, however, since the analysis focuses on the differences among the three model scenarios at the same point in time, and the extent of "incompleteness" is minor.

The primary focus of the analysis is on the Highland campus, for the following reasons:

(1) The trauma center is at Highland;

(2) Highland accounts for over 95 percent of ACMC's CMSP inpatient gross revenue, and 90 percent of CMSP patient days. Fairmont, through its emphasis on rehabilitation and long-term care, fills a major gap in treating sponsored patients that is not addressed by the private sector;

(3) Given Fairmont's emphasis, its high Medi-Cal volume is not threatened by the implementation of the Two-Plan Model for Medi-Cal managed care, which is directed to the AFDC population. On the other hand, Highland is highly vulnerable to competition for Medi-Cal patients;

(4) The only major capital-expenditure plan for ACMC relates to the Highland campus. A go-no-go decision on this plan is imminent, resting on a determination of the facility's future role; and

(5) Under current law, inpatient facilities at the Fairmont campus will have to be completely rebuilt by 2008, to comply with seismic safety standards. A decision on that campus' future can be postponed beyond the next few years, pending the willingness of the private sector to provide the level of long-term care offered at Fairmont.

The data analysis is combined with an assessment of the health-care environment in Alameda County and likely future developments in public financing for health care services.

III. THE ENVIRONMENT

A. Funding

Funding for ACMC is derived through a wide variety of sources, all of which are becoming more and more restrictive. Major sources of funds include:

(1) State funds, which are mainly "Realignment" funds earmarked for counties, derived from a portion of vehicle license fees and sales-tax revenue. For the current fiscal year, this source is expected to provide approximately $24.8 million, down from $32.8 million the previous year;

(2) Direct payments for patient care (e.g., Medi-Cal, Medicare, insurance, self-pay). Of approximately $100 million budgeted for the current year, $57.1 million is expected from Medi-Cal (excluding disproportionate-share payments);

(3) Disproportionate-share hospital payments, estimated at $30 million for the current year. These are federal Medicaid funds matched against transfer

payments from public hospitals and distributed to qualifying hospitals based on a statutory formula. They are expected to be cut in half in the next fiscal year; and

(4) County general fund contributions. No general fund expenditures are budgeted for this year. This traditional source of funding for county-obligation patients has been sharply reduced in many counties as county revenues have been diverted to the state, and disproportionate-share (DSH) revenue, which is tied to Medi-Cal volume, has become a major source of funding for county-indigent patients. With expected reductions in DSH payments, however, there will be few alternatives in the future to increased general fund support in many counties.

B. Payment Pressures and the Impact of Managed Care

Payment levels for health-care services have tightened considerably in recent years. While Medi-Cal payment rates have always fallen short of costs, they have fallen considerably short in recent years. In particular, hospital outpatient payment rates (generally frozen since 1982) now average less than 50 percent of costs, and few hospitals have received inpatient payment rate increases in recent years, under the Selective Provider Contracting Program. Medi-Cal and Medicare payment shortfalls have traditionally been off-set by inflated charges to private payors (cost shifting). This ability has largely evaporated with the proliferation of managed care; and it never was a viable option for county hospitals, which have a low mix of private-paying patients.

Besides severely restricting the hospital's ability to cost shift, managed-care payors have aggressively pursued alternatives to inpatient care. Complimented by advancements in medical science, inpatient utilization is dropping universally. Tight payment rates combined with shrinking volume is resulting in intense competition by hospitals for a shrinking pool of patient-care dollars. That competition has recently spread to Medi-Cal patients, notwithstanding that program's low payment rates.

Three managed-care models are being implemented by the Medi-Cal program in the State's urban areas.[1] The models are as follows:

(1) County Organized Health Systems (COHS), where designated county governments assume responsibility, on a capitation basis, for the entire Medi-Cal population within their jurisdictions. Four COHSs are currently operational -- Santa Barbara, San Mateo, Solano and Orange -- and one is scheduled for implementation later this year -- Santa Cruz. Under current federal law, no additional COHSs can be designated in California;

(2) The two-plan model being pursued in 12 counties. Under this model, all Aid to Families with Dependent Children (AFDC), and no-share-of-cost

Medically-Needy Families and Children will be required to sign up with one of two local HMOs. The major HMO is envisaged as a consortium of each county's safety-net providers -- the "local initiative" -- organized by the county boards of supervisors. The other HMO is to be a single, mainstream HMO selected by the State. The former is to be comprised of disproportionate-share hospitals. This model was intended to protect disproportionate-share hospitals, the most important of which in terms of Medi-Cal volume are county hospitals, and other safety-net providers that are dependent on Medi-Cal revenue. Local initiative health plans are to be Knox-Keene-licensed HMOs, and as such must eventually have an enrollee mix that is at least 25 percent non-Medi-Cal, non-Medicare.[2] Alameda County's Local Initiative, implemented January 1, 1996, is the first to become operational. Blue Cross has been awarded the Mainstream contract. In Alameda County, the beneficiary population covered under the two-plan model accounts for approximately 65 percent of total Medi-Cal beneficiaries, and approximately 30 percent of Medi-Cal patient days; and

(3) Geographic Managed Care (GMC) is being pursued in two counties -- Sacramento and San Diego. In Sacramento, it was implemented in April 1994. Implementation in San Diego is scheduled for 1996. While GMC covers the same beneficiary mix as the two-plan model, here beneficiaries choose from among a variety of mainstream plans -- seven in Sacramento. While neither of these counties has county hospitals, approved health plans are required to include safety-net providers (disproportionate-share hospitals, community clinics and major Medi-Cal physicians).

Notwithstanding the above-mentioned "safeguards", implementation of Medi-Cal managed care, combined with the inability of hospitals to be reimbursed for their excess capacity, is expected to place county hospitals at major risk of losing significant portions of their Medi-Cal patient loads. Protection of Med-Cal revenue is vital to the survival of most, if not all, county hospitals. One major factor that could ameliorate the competition for Medi-Cal patients in Alameda County is the decision (which is not yet final) by Kaiser-Permanente to close its Oakland hospital, and contract with other hospitals to provide inpatient care to Plan members.

C. Disproportionate-Share Funds

1. SB 855

Provision of care to Medi-Cal and other indigent patients is intertwined. This is evident in the manner in which supplemental funds are distributed to hospitals with high Medi-Cal and indigent patient loads. These hospitals are defined as Medi-Cal disproportionate-share hospitals (DSH) in SB 855. The DSH definition and payment formula are based on both Medi-Cal and indigent patient percentages. To compensate DSH hospitals for unreimbursed charity and county-indigent costs, disproportionate-share payments flow

through the Medi-Cal payment mechanism, in terms of supplemental payments for every Medi-Cal inpatient day. Thus, for example, a hospital with no Medi-Cal patient days and a high proportion of unsponsored indigent patients would receive no Medi-Cal disproportionate-share payments. This relationship is reinforced by the manner in which Medi-Cal managed care is being implemented in various counties, as discussed above.

As indicated above, ACMC expects to receive approximately $30 million in DSH funds in the current year, and $15 million in fiscal-year 1996-97. This reduction reflects new federal limits, a growing list of qualifying hospitals and a "pay-back" for increased payments in earlier years due to alignment of state and federal payment periods. A drop in DSH payments by this amount next year will create a major shock that will have to be dealt with through extensive cost cutting. Alameda County is not alone in facing such severe reductions; it will be joined by all counties currently dependent on DSH revenues. These counties will be working with the State Administration and Legislature and the federal government to attempt to minimize the reductions. To the extent major reductions remain, they will have to be dealt with through a combination of cost cutting, county general fund appropriations and new revenue sources.

2. SB 1732

Another source of future funding for ACMC is the SB 1732 program, should a decision be made to proceed with the planned building project on the Highland campus. This project is comprised of a parking structure and a critical care building, including a replacement emergency department and inpatient and outpatient services.

SB 1732 (1988) established the Construction/Renovation Reimbursement Program (CRRP), administered by the Department of Health Services as part of the Medi-Cal program. CRRP is intended to provide supplemental debt-service payments to disproportionate-share hospitals for eligible projects. Eligible projects are limited to construction and acquisition of fixed equipment. Medi-Cal's share of debt service payments is determined by the hospital's Medi-Cal percentage of inpatient days. The Medi-Cal debt-service share would vary from year to year based on the Medi-Cal patient days percentage, but would be subject to a floor. This floor, or lower limit, is 90 percent of the base-year percentage. The latter is determined by the weighted average Medi-Cal patient days percentage for the three years immediately preceding plan submittal to the Office of Statewide Health Planning and Development (OSHPD). Thus, if a hospital's three-year average is 60 percent, the Medi-Cal funding floor would be 54 percent of debt-service payments.

Eligible projects must be available to Medi-Cal hospital patients, must be on behalf of Medi-Cal contracting hospitals (through the Selective Provider Contracting Program), must be financed through tax-exempt debt, and must involve at least $5 million in capital expenditures (construction and fixed equipment), unless they are for the purpose of correcting licensing or accreditation deficiencies. With some exceptions, plans for eligible projects must have been filed with OSHPD between July 1, 1989 and June 30, 1994. Thus, the "window" is now

closed and costs to the program are predictable. Since the bill's enactment in 1988, the program has become more expansive through several amendments that, for the most part, extended the plan-submittal window for specific, narrowly-defined projects (up to June 30, 1995).

Under the statute, the state pledges to bond holders that until debt service is fully paid, the state will not limit or alter the rights vested in the hospital to receive supplemental reimbursement.[3]

D. Medicaid Reform

It is likely that the Medicaid program will undergo significant change within the next few years. While Congress intends to drastically curtail growth in the program and convert this federal entitlement into a block-grant program with few restrictions on states, the President insists on maintaining federal guarantees and lower cuts in growth. The likely result is increased state flexibility coupled with decreased federal and state funding in terms of real dollars. It is possible the increased state flexibility could decouple Medicaid funding for county-indigent care (through DSH payments) from Medi-Cal volume, enabling Medi-Cal funds to directly support county-indigent care. It is also possible the advantages of this new flexibility would be more than off-set by Medi-Cal funding reductions in general.

At the same time, the need for a viable network of safety-net providers may be increasing. Given the already growing uninsured population and the lack of political will to enact universal health coverage, future Medi-Cal and Medicare funding cuts are likely to swell the uninsured ranks even further.[4] First, cutting Medi-Cal funding will directly reduce Medi-Cal access and remove beneficiaries from the Medi-Cal rolls. Second, cutting Medi-Cal and Medicare payments will, to some extent, lead to a cost-shift to some private payers (e.g., insurance carriers, HMOs, self-insured employers) who will in turn be forced to increase their health-insurance premiums, which will result in a reduction in health-insurance coverage in terms of both benefits and insured lives. Thus, greater strains will be placed on safety-net providers to treat unsponsored patients.

E. Summary

ACMC, and many other county-operated health systems, are faced with a set of nearly bewildering pressures and challenges. Its major funding sources are shrinking. County general fund revenues are no longer a predictable source of funds. ACMC's ability to provide necessary care to unsponsored, county-indigent patients is dependent on its ability to draw a sufficient number of Medi-Cal patients. That ability is severely threatened by competition from private hospitals with increasing excess capacity. While county-hospital funding may be less secure, inevitable cuts in overall Medicaid funding, without establishment of a national health insurance program, will lead to an expansion in the number of county-indigent patients. The ability to successfully compete for Medi-Cal patients will in all likelihood require capital investments on the part of ACMC so that its facilities and services will attract Medi-Cal

patients with private-sector choices. If ACMC is unsuccessful in its efforts to protect its funding sources, it is likely the County will not have sufficient resources to meet its indigent-care responsibilities through private-sector contracting. This shortfall in resources will largely be the result of the loss of ACMC's DSH funds of approximately $30 million in the current fiscal year and an estimated $15 million in the coming fiscal year. These funds are not transferrable to other hospitals. (To qualify for DSH status requires high Medi-Cal and/or unsponsored patient loads, and there is an approximately two-year lag between achieving sufficient patient volume and attaining qualification.) Should ACMC cease to operate as a general-acute hospital, there will be a major tug-of-war between the County's indigent-care obligation and the private hospitals' ability and willingness to accommodate large numbers of these patients without payment.

IV. EXAMINATION OF THE THREE MODELS

A. Treat and Transfer Facility

Under this scenario, ACMC would only be a trauma/emergency hospital. Once patients are stabilized, they would be transferred to other hospitals. Outpatient services would continue to be provided at both campuses. All inpatient services at the Fairmont campus would be discontinued. All inpatient services provided at either campus to CMSP patients who are not trauma/emergency or have been stabilized would be provided at other hospitals under contract. In addition, other county-obligation patients, such as jail patients, will have to be accommodated in private facilities.

1. Volume, Necessary Capacity, Revenue and Expenses

The primary data source is the ACMC billing records for calendar-year 1995.[5] To assess this option, data on both inpatient and outpatient volume and charges are analyzed for patients identified as trauma or emergency (i.e., treated as a trauma or emergency patient). As a treat and transfer facility, ACMC's patient base may not be limited to "pure" trauma patients, but would most likely include some non-trauma emergency patients as well. The analysis presented here uses two definitions -- trauma and all emergency patients. The latter provides inflated estimates since many patients treated in the emergency room and subsequently admitted may not be in need of emergency care, and once admitted, these patients are not subsequently transferred to other facilities once they are stabilized. On the other hand, the former (i.e., trauma patients only) may be too restrictive.

Table 1 provides data on gross revenue and inpatient volume (discharges, length of stay, patient days and average daily census) for inpatient trauma according to service. Note that there is a service identified as "trauma", which is a division of the surgery department. These patients were not subsequently assigned to a "regular" service. Note that for this restrictive definition of trauma/emergency, an average daily census (i.e., occupied licensed beds) of 12 results. Accommodating this census would require approximately 20 beds, to

allow for daily census fluctuations. Average charge per patient day is $5,472. Note that average daily censuses (ADC) of one or more appear in only two regular services (neurosurgery and orthopedic surgery). The largest ADC (8) is in the unassigned trauma classification. While there is very low volume in many services, to maintain its trauma-center designation would require ACMC to maintain most of its service capabilities.

Table 2 shows equivalent data for emergency inpatients. Here the average daily census rises to 87, and charge per patient day drops to $2,386. This census would require 125-145 beds. ADCs of greater than one appear in most major services.

Table 3 presents inpatient trauma data according to source of payment, and cost per discharge and patient day. Costs are estimated by applying the Highland campus' cost-to-charge ratio of 68.5 percent to gross revenue for each payor. Note the largest payor for inpatient trauma is Medi-Cal. Note also that the estimated Medi-Cal per diem cost is $3,287. With Medi-Cal payments negotiated on a competitive basis, and with average per diems below $1,000 for even the most sophisticated hospitals, achieving payment rates even approaching $3,000 from Medi-Cal (or any other payor) is unlikely.

Table 4 provides equivalent data for all emergency patients (including outpatient data, which is discussed below). Again, Medi-Cal is the major payor, with an estimated per diem cost of $1,672.

In projecting costs for these options, it should be noted that adequate adjustments have not been made for the fixed cost component. What is presented here are estimates of average costs attributed to these patients within the context of the current programs and overall volume of the Highland campus. Should the non-trauma/emergency patients volume be eliminated, the fixed costs would remain. While staffing could be reduced, the reductions would be far from proportional to the patient volume loss. Supply purchases may be cut proportionally, but current capital expenditures (i.e., depreciation and interest on existing plant and equipment) would remain fairly constant. Thus, the unit costs (e.g., per discharge, per patient day, per outpatient encounter) would be substantially above those presented here.

Table 5 shows inpatient and outpatient gross revenue and average daily census data according to payer, for all Highland patients and for trauma and emergency patients only. Total gross revenue for all patients is $223 million, falling to $94 million (a 58 percent drop) if only emergency patients (inpatient and outpatient) are served, and falling further to $31 million (an 86 percent drop from total) if only trauma patients are served. The ADC falls from 222, to 87, to 12, respectively.

2. Implications

The practicality of this type of hospital is doubtful. To be a trauma center, a hospital must provide a fairly comprehensive array of inpatient services, and have substantial back-up personnel and facilities. If volume falls between 38 and 86 percent (a midpoint of 62

percent), an adequate patient base to support a full-service hospital would not exist. In general, hospitals of substantially less than 200 beds in urban areas do not make economic sense. Where geographic access is not a primary constraint, a population base is best served by fewer, and larger, hospitals, for both economic and quality reasons.

In addition to the problem of appropriate size is the loss of substantial DSH payments, which are tied to Medi-Cal patient days. Under the restrictive definition of treat and transfer, nearly all DSH payments would be eliminated. Table 5 suggests that Medi-Cal patient days (and, hence, DSH payments) would drop by 94 percent. For the current year that would cost ACMC approximately $28 million in net revenue. In 1996-97, assuming DSH net revenue of $15 million at current total volume, $14 million would be lost. Under the expansive definition of treat and transfer (i.e., retaining all emergency patients), DSH net revenue would fall from $30 million to $18 million in the current year (a $12 million loss), and from $15 million to $9 million in the 1996-96 fiscal year (a $6 million loss).

Because of the cuts being considered in Congress, the continued availability of DSH funds at approximately current levels is being called in to question. At this time, however, there is no proposal on the table which would specifically eliminate such funds. The SB 855 program accounts for approximately $1.1 billion in federal Medicaid funds flowing to California annually. Of this, the State Department of Health Services receives over $250 million to partially support its administrative functions. Should this source of revenue be significantly curtailed without replacement from another source, all counties operating hospitals (in addition to the State of California) will be placed in severe jeopardy, to the extent that a major reduction would not be politically feasible. If there are aggregate reductions, they are likely to be complemented by a shifting of the remaining funds away from private disproportionate-share hospitals, to county hospitals through greater weight being given to outpatient services and to services provided to unsponsored patients.

Thus, while not a certainty, DSH funds at some level should be available for the intermediate term at least. To the extent increased flexibility results in decoupling DSH from Medi-Cal volume, the DSH losses projected here could be reduced. Under current law, however, DSH payments are fully driven by Medi-Cal volume.

Given that DSH revenue is vital for the support of CMSP, such losses would have to be offset by substantial county general fund appropriations to enable the County to meet its Section 17000 obligation through contracting with private hospitals. All non-trauma/emergency CMSP would have to be contracted to the private sector. With projected DSH losses of $12 million to $28 million in 1995-96, and $6 million to $14 million in 1996-97, private hospitals would be required to incur aggregate losses that could approach a similar magnitude, which would be only partially offset by profits from receiving ACMC's former Medi-Cal patients. In fact, as discussed in Section C below, private hospitals contracting to care for ACMC's CMSP patients would incur costs of $42.4 million, receive realignment revenue of $24.8 million and, thus, incur losses of $17.6 million from this arrangement.

Another ramification of this model is the loss of the ACMC teaching program, with its associated Medicare direct and indirect graduate medical education subsidies. A recent study suggests the teaching program earned $3.3 million in profits in fiscal-year 1994-95.[6]

In terms of necessary capital expenditures, while a substantial portion of the main Highland building would become empty, the emergency department would still have to be replaced. Rather than moving to the new planned critical care building, the remodeled emergency facility could most likely be accommodated in the main building, and the planned parking structure may not be necessary. These capital expenditures, however, would not be eligible for SB 1732 assistance.

A component of the treat and transfer model is discontinuance of inpatient services at the Fairmont campus, and thus contracting for Fairmont's CMSP inpatient services at private hospitals. The CMSP inpatient volume at Fairmont is low, a 1995 ADC of 2.5. Thus, virtually the entire patient load has a payor sponsor, and is not an obligation of Alameda County. Fairmont, with its rehabilitation and high-acuity, long-term care role, fills a major gap in the local health system. While an integral and valuable component of the ACMC integrated health system, discontinuance of Fairmont's inpatient services should not cause the County significant legal problems with regard to its Section 17000 obligation. Since, however, the private sector has elected not to compete for Fairmont's sponsored patients, closing its inpatient program would not appear to benefit the private hospitals. Unless major Medi-Cal payment shortfalls are projected, decisions on the future of that facility should be based on the costs and benefits of its replacement prior to 2008 to meet new seismic-safety standards, under SB 1953 (1994).[7] This law will require inpatient facilities to be in reasonable conformance with at least 1960s building codes by 2008.

B. Trauma Center and a CMSP Hospital

1. Volume, Necessary Capacity, Revenue and Expenses

Under this scenario, ACMC would remain a trauma center, treating all trauma patients, regardless of payor source, and be the primary hospital provider for CMSP patients. CMSP patients would be treated regardless of admission status. Non-CMSP patients, however, would only be treated if they were trauma patients, and once stabilized, transferred to other hospitals.

Table 6 provides data for Highland and Fairmont on CMSP inpatient and outpatient gross revenue and estimated costs per discharge and per patient day. Note that of $62 million in gross CMSP revenue (in-and out-patient) for both campuses, $54 million (87 percent) is accounted for by Highland. Of the CMSP combined ADC of 24, 22 (90 percent) occurred at Highland. Note also the high length of stay (and relatively low per diem cost) at Fairmont, reflecting the long-term-care nature of the Fairmont patient load.

Table 7 compares, for Highland, inpatient volume and gross revenue according to service for three categories of patients -- all inpatients, emergency admissions, and trauma

admissions. The bottom row in the table excludes discharges and patient days in the nursery since some of that volume is in unlicensed bassinets and is not normally counted as discharges and patient days, and excludes volume and revenue for the John George Pavilion, which is on the Highland license. (On the other hand, neonatal intensive care [NICU] discharges and patient days should be included.) This data base does not permit identification of NICU patients. With these exclusions, the total ADC of 126 drops to 22 for CMSP patients only, and 33 for trauma and CMSP combined. Table 8 provides a calculation of ADC for CMSP plus trauma, excluding the CMSP patients that are already included in trauma. That ADC is 32. Accommodating this ADC would require a hospital with approximately 50-55 beds. Again, maintenance of the trauma center would require maintenance of most services, although ENT, obstetrics, nursery, ophthalmology and urology most likely could be eliminated.

Table 9 provides CMSP inpatient data for Highland, including gross revenue per discharge and per patient day. The per diem charge of $2,933 is close to that for all patients. Thus, it appears that CMSP patients have acuity levels (on a per-diem basis) similar to those of other Highland patients.

2. Implications

The implications of this scenario are similar to those pertaining to the treat and transfer model, with one exception. CMSP patients would continue to be treated at ACMC, rather than contracted to the private sector. The loss of virtually all DSH revenue, however, would have to be offset by considerable general fund contributions, nearly $30 million in the current year. DSH losses are projected at the higher level under the treat and transfer model since Medi-Cal patient days, which drive DSH payments, would only derive from trauma patients.

C. A Competitive Full Service Hospital

1. Volume, Necessary Capacity, Revenue and Expenses

Under this scenario, ACMC would maintain its current payor base and take initiatives necessary to maintain that base through the remainder of this decade, and beyond. Given the movement of formerly inpatient services to the outpatient setting and the implementation of Medi-Cal managed care, private providers who, in the past, did not view Medi-Cal as a desired payor source, are increasingly competing for this market segment. In the last year, ACMC has experienced a drop in its Medi-Cal obstetrics patients due to competition from private providers. To effectively compete for this vital market segment will require efforts on the part of ACMC to emulate private-sector providers in terms of service and amenities.

Table 10 shows Highland inpatient volume, gross revenue and estimated costs according to payor. (Note that in this data base, Medi-Cal-sponsored mental health patients are not identified as such. All mental health is classified as a distinct payor source.) Of total

inpatient gross revenue of $136 million, $75 million (55 percent) is accounted for by Medi-Cal (excluding Medi-Cal mental health patients). A clearer picture is provided by Table 11, which shows total and Medi-Cal inpatient volume and gross revenue according to service, enabling the exclusion of mental health (John George Pavilion). This shows Medi-Cal (excluding mental health and nursery) accounting for 57 percent of total patient days. The total ADC, excluding mental health and nursery, is 126. Cost per patient day for Medi-Cal patients is estimated to be $1,961.

This ADC of 126 is consistent with needed capacity of 175 beds or less. Licensed beds at the Highland campus (excluding the John George Pavilion [JGP]) are 236. Many of these beds, however, do not exist, as the space has been converted to other functions (i.e., administration and outpatient use). According to the Office of Statewide Health Planning and Development (OSHPD) Quarterly Financial and Utilization Reports covering the 12-month period ending June 30, 1995, the Highland campus (including the John George Pavilion) has 274 available beds. Subtracting the 83 licensed beds at the John George Pavilion leaves 191 available beds at Highland, reasonably close to the 175-bed requirement.

Table 13 provides comparative data on the all hospitals in Alameda County. It shows that on the basis of available beds, Highland (including JGP) has the second highest occupancy rate among all general-acute hospitals (77 percent). It shows that both ACMC campuses combined account for 47 percent of all Medi-Cal patient days and 45 percent of all county-indigent patient days. (Thunder Road Chemical Dependency Hospital accounts for 49 percent of county-indigent patient days, but only 4 percent of county-indigent expenses. ACMC accounts for 90 percent of such expenses.)

Table 14 presents 1992 Medi-Cal paid-claims data on beneficiaries residing in Alameda County, identifying patient days on behalf of those aid categories that will be required to enroll in a managed-care plan. While these data are not current, they are shown here to provide a perspective on the relative market shares of Medi-Cal patient days and each hospital's dependence on those beneficiaries that will be required to enroll in one of the two managed-care plans.[8] Individual data are shown for hospitals with 1,000 or more non-cross-over Medi-Cal patient days. Since California Children's Services (CCS) patients will be covered under fee-for-service, these patient days on behalf of beneficiaries in the mandatory aid codes are subtracted to arrive at net mandatory patient days. As a percent of total non-cross-over patient days, net mandatory patient days are 28 percent for the county as a whole and 29 percent for Highland. Thus, over 70 percent of Highland's 1992 Medi-Cal patient days would not be covered under the two-plan model. The more than 8,000 patient days that will be covered, however, are significant. Given the county-wide patient-day utilization rate for this population (265 days per 1,000 beneficiaries), these 8,319 patient days translate into 31,358 enrollees. This projection does not account for the likely drop in per-capita utilization that should accompany movement to a capitated system. In Alameda County, approximately 170,000 Medi-Cal beneficiaries are in the mandatory aid codes. Approximately 75,000 are "targeted" for the Local Initiative plan.[9]

This suggests that to protect Highland's 8,319 mandatory patient days (that occurred in 1992), the ACMC system will have to enroll over 30,000 beneficiaries. While this would be an ambitious task, it may not be enough. Since Highland does not have an inpatient pediatrics service, ACMC may have to enroll even more beneficiaries to protect its patient-day base. Approximately 60 percent of the mandatory beneficiary population is 15 years of age or less. This group, however, has a lower utilization rate than the older cohorts, approximately one-third the adult rate. Thus, in terms of adult enrollees, approximately 19,000 would be required for Highland. Beneficiaries in the mandatory categories, however, are families and children. It is unlikely, for example, that a mother and her children would enroll in different plans. If they enroll in the ACMC system, the children would not be hospitalized at Highland; they would be treated in the ACMC clinics and presumably hospitalized at Children's Hospital. Highland's Medi-Cal patient base would be protected through a combination of enrolling a sufficient number of adults through both the Local Initiative and the Mainstream plans, and through subcontracting with the Mainstream plan for inpatient care for those enrollees assigned to non-ACMC physician groups for primary care.

Equivalent paid-claims data for Highland for 1995 indicates a similar number of total Medi-Cal patient days (27,824), but substantially fewer mandatory patient days (5,933). According to the 1995 data, mandatory patient days represent only 21 percent of total Medi-Cal days. And of these 5,933 mandatory patient days, 29 percent are in obstetrics. Enrollee equivalents based on 1995 data would be 22,364 and 13,423 for total enrollees and adult enrollees, respectively. These represent far more attainable enrollment targets. Table 15 presents these Medi-Cal paid-claims data for Highland by service.

2. Appropriate Strategies

The Setting

Competing for Medi-Cal patients is a relatively new phenomenon. Given Medi-Cal's relatively low payment rates (on average, 50 to 60 percent of allowable costs for hospitals) and the belief by some providers that a high Medi-Cal load is not conducive to attracting private patients, most private hospitals did not try to expand their Medi-Cal patient base. That situation has changed for some hospitals. First, for those hospitals that have always had a high proportion of Medi-Cal patients, the availability of DSH payments has made Medi-Cal a profitable business line. In Alameda County, however, this is not a competitive factor since only Children's Hospital Medical Center and ACMC qualify as DSH providers. Second, in the late 1980's, to deal with a shortage of physician and hospital capacity available to Medi-Cal patients in the obstetrics area, Medi-Cal payments to physicians for prenatal care and deliveries were increased to levels comparable to private payors, and the California Medical Assistance Commission (CMAC) began to negotiate separate inpatient rates for obstetrics. This has served to make Medi-Cal obstetrics patients far more desirable than previously, to both hospitals and physicians, especially the latter. Third, the proliferation of managed care in the private sector and advancements in medical science (e.g., orthoscopic and laser surgery) have resulted in a dramatic reduction in inpatient utilization, leaving hospitals with more and

more empty beds, with fewer charge-paying purchasers to subsidize them. And fourth, with the movement to Medi-Cal managed care, many hospitals and physicians believe they manage this population in a cost-effective and profitable manner.

It is far from certain, however, that this line of business will remain profitable or desirable to a large number of private-sector providers in the long run. Alameda County presents a unique circumstance. While the private-sector hospitals have been competing aggressively for Medi-Cal patients, especially obstetrics patients, Kaiser-Permanente has recently announced tentative plans to close its Oakland hospital, in favor of contracting with other hospitals. Should these plans be implemented, competitive pressures for Medi-Cal patients may ease. A final decision has not yet been made.

At this time, ACMC should expect to have to compete to retain its Medi-Cal patient base in the mandatory aid categories, a large portion of which is obstetrics-related. It should not be forced, however, to make considerable capital investments for purely marketing reasons, but to remedy current deficiencies. ACMC should capitalize on its competitive advantages in terms of a committed medical and support staff accustomed to dealing with hard-to-manage indigent populations, its considerable capabilities due to its extensive teaching program, its dependability at a time when the desirability of Medi-Cal patients to many private providers may be only a fad, and its integrated health system involving a network of county-operated and private clinics linked to ACMC.

It should be noted that Fairmont, given its orientation and lack of competition, at this time appears to be insulated from the type of competition discussed here.

Capital Investments

ACMC should consider reasonable efforts to improve its plant and equipment in a cost-effective manner over the next three-to-five years. The main Highland building, which houses the inpatient facilities, was completed in 1970 and should be adequate to meet the 2008 seismic-safety threshold. The inpatient facilities are generally adequate. There appear to be four major problems on the entire campus: (1) the emergency department is in need of major renovation; (2) the surgery facilities (in- and out-patient) are inadequate; (3) outpatient services are cramped in some areas and spread-out among several buildings in a confusing manner; and (4) parking space is inadequate.

These problems have been recognized in the capital plan adopted by ACMC, which includes construction of a parking structure and of an eight-story critical care building. The latter is to include, in addition to emergency/trauma and surgical facilities, intensive care beds and an imaging center. Architectural plans for the critical care building were filed with OSHPD in time to qualify for financial assistance under SB 1732. The total cost of this project was estimated to be approximately $90 million. Since the plans incorporated only shelled space for a portion of the building (which does not qualify for SB 1732 since this space would not be accessible to Medi-Cal patients), approximately $60 million in planned

capital expenditures would qualify for SB 1732 assistance. Thus, assuming ACMC's Medi-Cal patient-days percentage is 50 percent, SB 1732 will yield $30 million in subsidies.

On the full $90 million project, annual debt-service payments (30 years at 6 percent interest) would be $6.5 million, with $2.2 million in SB 1732 subsidies, for a net county contribution of $4.3 million. If the project could be completed for $60 million, for example by eliminating the shelled floors and those earmarked for ICU and radiology, SB 1732 subsidies of $2.2 million might remain, but the net county contribution would drop to $2.2 million (on a total debt-service payment of $4.4 million). On the other hand, it may be cost-effective in the long term to include some shelled space for clinic space. The cost implications of these alternatives will have to be assessed. While it may be less costly overall to make extensive alterations in the current main building than to move ahead with the critical care building (or a portion of that building), such a project will not qualify for SB 1732 matching funds and would in all likelihood be more costly to the County.

It appears that to be able to retain a substantial portion of Medi-Cal patient days associated with managed-care enrollees, a significant portion of the construction discussed here will be necessary. These capital-investment decisions will not bear fruit overnight. In the meantime (i.e., until the projects are available for patient use), ACMC will have to fully rely on its other, considerable attributes and attempt to make cosmetic appearance changes and minor renovations in the existing buildings as appropriate. To the extent these capital expenditures (or other initiatives) require general-fund subsidies, it should be noted that of all departments of county government ACMC is unique in that its viability depends on its ability to compete with the private sector.

Non-Capital-Intensive Measures

Several measures not involving major capital investments are worthy of consideration. They mainly revolve around ACMC capitalizing on its major attributes.

ACMC has more experience in providing care to Alameda County's indigent residents than any other provider. The medical staff, nursing staff and social-services personnel are familiar with the indigent population's unique needs. Private-sector providers do not have this experience and many will find the adjustment difficult, not worth the effort, or impossible. Medical, cultural and linguistic characteristics of this population can best be accommodated by the ACMC staff resources. This should be communicated to the ACMC patient base.

ACMC has the potential to form the nucleus of an integrated health delivery system, including long-term-care facilities (Fairmont), mental-health facilities (John George Pavilion), public-health clinics, a network of county-operated and private-non-profit community clinics (community-based organizations [CBOs]), and extensive specialty resources through its teaching program. This system should provide the base to enable the necessary continuity of care and control mechanisms to be a successful health system. To take full advantage of this potential requires investments in necessary information systems to enable and coordinate the

flow of data on individual patients and the medical care process among the various facilities and services.

Coordination among these components in ACMC's best interests requires at a minimum that the first choice for hospital and medical specialty referrals on the part of all affiliated clinics is ACMC. Unless there is a distance problem, or a clinic is located adjacent to another hospital, or ACMC does not have the required services (e.g., pediatrics, cardiovascular surgery), all clinics, including CBOs, should be required to refer within the ACMC system (i.e., hospital and specialty clinics). For such coordination to work in the patient's best interests requires the ability of ACMC's programs to accommodate the referring clinics through timely appointment scheduling.. Physicians representing ACMC, CBOs and other community physicians should be brought together to identify improvements needed at ACMC to facilitate establishment of an expanded referral base.

A mechanism being implemented in other public hospitals is establishment of two tracks for patient care, one for insured and Medi-Cal patients, and another for CMSP, since the latter are not being enticed by private-sector providers. While the level and quality of patient care would be equivalent between the two tracks, the former would have more amenities, including improved scheduling, more attractive facilities and greater participation by private physicians. The feasibility of such a two-track system should be explored. While it may be controversial, to the extent it contributes to the financial viability of ACMC, it improves the latter's ability to maintain access for county-obligation patients.

Better use of existing clinic space would greatly improve the marketability of ACMC. For example, obstetrics, gynecology and pediatrics clinics could be placed in close proximity and scheduling could be coordinated, to enable "one-stop" shopping on the part of mothers and children.

The teaching program provides an opportunity for ACMC to enhance its reputation in various medical specialties, and to enhance its private patient base. For example, in cooperation with private hospitals, ACMC could develop certain "Centers of Excellence" (i.e., specific illnesses for which ACMC would have a regional reputation). One area for such a center could be disease management of cancer patients.[10] Another area could be workplace injuries, as the following quote of Quentin Young, M.D., former director of medicine at Cook County Hospital, illustrates:

> *"My job was to attract young doctors to the place. They came and worked their butts off. Occupational medicine was introduced into a public hospital. The county board objected: 'It's a hospital for indigents. They don't work.' We pointed out that our wards were full of people who were victims of the workplace; lead poisoning, brain damage, injuries. Today, Cook County has the largest occupational training program in the country."*[11]

The ability to capitalize on the teaching program in this manner, besides enabling the building of a private patient base, will also facilitate competition for Medi-Cal patients.

Efforts should be made to encourage county employees to use ACMC and its affiliated physicians through financial incentives, in terms of reduced health-insurance premiums, deductibles or coinsurance.

Another obvious mechanism to retain Medi-Cal managed-care patients is through the Local Initiative, in which ACMC, as the major DSH hospital in Alameda County, is the nucleus. Enrollees should be encouraged to select primary care providers (i.e., county clinics and CBOs) affiliated with ACMC. If they are unable to make a selection, they should be defaulted into the ACMC network.

The importance of marketing the ACMC system to the Medi-Cal population cannot be over-emphasized. In this regard, the recent managed-care experience of University of California, Davis Medical Center (UCDMC) should be noted. In April 1994, Geographic Managed Care (GMC) was implemented in Sacramento County. Under that program, all Medi-Cal beneficiaries in the AFDC, Medically-Needy Families (no-share-of-cost) and Medically Indigent Children categories are required to select from seven managed care plans (excluding four dental plans) to receive all their Medi-Cal covered health services. One of those plans is a Primary Care Case Management (PCCM) plan sponsored by UCDMC. While the largest Medi-Cal provider in Sacramento County prior to implementation of GMC, the UCDMC plan has secured the smallest market share of GMC enrollees, approximately 7 percent (11,000 enrollees out of a population of 150,000).[12] According to Department of Health Services (DHS) representatives, this poor experience is the direct result of UCDMC's refusal to market its plan to the Medi-Cal population. While UCDMC, as a trauma center and the former county hospital, has a public-hospital image, it also has unique capabilities that should be valued by the Medi-Cal population (e.g., extensive tertiary-care facilities, an abundance of highly qualified physicians, cultural sensitivity and transportation programs serving the indigent population). It elected not to exploit its positive attributes during the early stages of enrollment, and has been unable to recover.

Finally, consideration should be given to enlisting the support of the private hospitals in two regards -- protecting ACMC's Medi-Cal patient base and coordinating programs with ACMC.

The major private hospitals should be made aware that ACMC's ability to maintain its trauma center and to be the provider of last resort is contingent on its ability to maintain its Medi-Cal patient base. Without this payment base, DSH payments, which heavily subsidize ACMC's CMSP patients, will disappear. Without these subsidies, ACMC will be forced to discontinue its inpatient services at Highland. The County would then contract with private hospitals to provide care to CMSP patients at the level it could afford (e.g., realignment funds plus the current general fund contribution, which is zero!). The loss of tens of millions of dollars in DSH funds, which heavily subsidize the CMSP program, will require private

providers to incur losses approaching that level from treating these patients. Such losses will only be ameliorated through dramatic cuts in service to this population, and accompanying deterioration in health status, which would be politically intolerable, and through profits from the shifting of ACMC's Medi-Cal patients to the private hospitals (which, in all likelihood, would not be sufficient to offset these losses). In such a scenario, the County may be able to recover some costs (to sweeten the contracting pot) by selling the Highland facility to a private for-profit or non-profit hospital chain, which would operate it as a private hospital, competing for private, Medicare and Medi-Cal patients. The new entity would be free to discontinue the trauma center and would be under no obligation to contract to care for CMSP patients.

Table 16 represents an attempt to simulate the impact of CMSP contracting on the private hospitals. It starts with total CMSP gross revenue at Fairmont and Highland, then applies the weighted cost-to-charge ratio at both facilities (69.7 percent) to estimate CMSP costs. Thus, gross revenue of $61.7 million implies costs of $42. 4 million.[13] When these costs are compared to ACMC's 1995-96 realignment revenue of $24.8 million and the zero county general fund allocation, there is a payment shortfall of $17.6 million. ACMC has been able to offset this shortfall with DSH funds. DSH funds, however, would not directly transfer to the private hospitals. To the extent one or more private hospitals became eligible for DSH funds in the future due to the transfer of CMSP and Medi-Cal patients, there is an approximate two-year lag between the new patient volume and DSH qualification. Along with the new CMSP volume would come Highland's Medi-Cal volume. Table 15 also estimates Highland's costs for these patients and Medi-Cal net revenue. Note that net revenue is 60 percent of costs. (This shortfall has also been offset by DSH funds.) It is highly unlikely that the incremental costs to the private hospitals of the new CMSP and Medi-Cal volume would be sufficiently below the total costs estimated here to offset the expected payment shortfalls to an acceptable extent.

To protect the private hospitals from this scenario, mechanisms should be explored through, for example, Local Initiative policies to protect ACMC's Medi-Cal patient base.

In addition, under SB 697 (Torres), enacted in 1994, not-for-profit hospitals, either alone or through other organizational arrangements, are required to conduct a community needs assessment and to develop a community benefits plan. These plans are to be filed with OSHPD. ACMC should initiate a process to enable all local hospitals to work together in this effort. This mechanism could be used to jointly plan future programs and to establish an organized, public process for assessing the respective roles of each hospital in the best interests of the community. This would create an ideal forum, for example, for planning the Centers of Excellence programs discussed above.

V. COORDINATING EFFORTS WITH PRIVATE HOSPITALS

From the analysis discussed above, it appears there are only two feasible options:

maintain ACMC as an institution capable of attracting a sufficient Medi-Cal revenue base, and related DSH subsidies, or cease inpatient operations altogether, in favor of private-sector contracting for county-obligation patients. After weighing the risks of the latter scenario, should the Board of Supervisors decide to close ACMC as an inpatient facility, and contract with private hospitals to fulfill its Section 17000 obligations, the elements listed below should form the foundation of such a policy.

Conditions for Delegating County Responsibilities to Private Hospitals

1. The private hospitals should make a legally-binding commitment to provide mainstream care to all patients in need of such care, regardless of diagnosis (e.g., AIDS, psychiatric), social status (e.g., homeless, jail patient), or payer source (e.g., Medi-Cal, unsponsored).

2. The hospitals' track records in treating the indigent (especially Medi-Cal) should be established, and generally accepted by the area's indigent advocates. Many of these patients are not simply a new line of business or a collection of capitated lives. They have a myriad of social and medical problems that are difficult to manage, requiring medical and allied-health personnel with particular sensitivities.

3. The hospitals' commitment should be for the long run (i.e., 25-30 years). Once the county hospital is closed, it is unlikely ever to open again.

4. The general-fund exposure to the county should be reasonable and predictable. (It is currently zero.) The private hospitals will be the beneficiaries of substantial incremental revenue and patients to fill their empty beds, especially from the county hospital's former Medi-Cal patients. The incremental costs of this new volume are likely to be below current average costs.

5. If a major rationale for closing the county hospital is that services should be consolidated, coordinated and integrated in the private system, there should in fact be a private "system." That is, the private hospitals should coordinate and integrate services among themselves in their community's best interests. This will improve care, contain costs and increase the financial viability of the local health system. Consideration should be given to their forming a not-for-profit joint-venture corporation to coordinate provision of care, collect funds from the county and disburse funds to the member hospitals. The viability of this entity should be guaranteed by its members.

6. There should be a maintenance of effort requirement regarding the hospitals' provision of charity care, so that the county will not be charged for services previously provided at no charge.

7. The hospitals should be financially viable, so that they will not come back to the county a few years later to change the terms of the agreement, after the county has lost all its

leverage.

8. Given the unique nature of this patient population and given that the county's medical and nursing staff are accustomed to this population, maximum effort should be made to:

(1) Assure that the county medical staff will be given the same privileges at the private hospitals; and

(2) Assure that the staffing increases at the private hospitals made necessary by the incremental volume will be accommodated by former county employees.

9. The private hospitals should assure their seismic safety for the length of the long-term agreement. Those hospitals with plants that are likely to be determined out of compliance with seismic codes, should establish a sufficient reserve account to make the necessary corrections when required by OSHPD.

VI. IMMEDIATE IMPLEMENTATION STEPS

Efforts necessary to gear up ACMC to be a full-service, competitive hospital should begin immediately after authorization by the Board of Supervisors. Assuming such action takes place in mid-March, the following implementation schedule for the near term should be considered:

Activity	Commence	Complete
Convene group of ACMC, CBO and other physicians to identify short-term and long-term actions to expand referral base	March 15	April 30
Develop groundrules for CBO referrals	May 1	June 28
Reassess plans for Highland critical care building	March 15	June 3
Negotiate changes in plans with OSHPD	June 4	June 28
Reassess Local Initiative default procedure	March 15	April 15

Activity	Commence	Complete
Develop plans for reorganizing and streamlining clinic space	April 15	June 14
Develop marketing plan for ACMC for Local Initiative and Mainstream	May 1	June 28
Develop plans for encouraging county employees to use ACMC and its clinic network	April 15	June 28
Implement above plans and procedures	July 1	As appropriate

The above matrix identifies the steps needed to address the most urgent needs that do not require major expenditure commitments. The urgency with respect to the critical care building is based on the need to meet potential OSHPD concerns regarding modifications to final plans submitted in 1994 that will not trigger a new submittal (so that SB 1732 eligibility can be protected). The activities identified above should generally be pursued concurrently. Under this schedule, by the start of the next fiscal year, ACMC should have policies in place and plans in place to enhance its competitive position. Other initiatives proposed in this report (e.g., centers of excellence) should be pursued on a timely basis, but do not appear to be as urgent as the need to immediately accommodate the CBOs and secure an essential referral base.

END NOTES

1.See the Legislative Analyst's Analysis of the 1995-96 Budget, for a summary of these programs.

2.Expanding Medi-Cal Managed Care, California Department of Health Services, March 31, 1993, p. 56.

3.Welfare and Institutions Code, Section 14085.5 (b)(5)(A).

4.The number of Californians with no health insurance, Medicare or Medi-Cal coverage increased by 273,000 between 1992 and 1993, to over 6.5 million individuals. See E. Richard Brown, "Health Insurance Coverage in California, 1993," UCLA Center for Health Policy Research Policy Brief, April 1995.

5.Reliance on billing data for trauma/emergency patients is likely to cause an undercount since during 1995 bills were apparently not produced for a significant number of emergency patients. (Letters from Gary P. Young, MD to Henry Zaretsky, December 21, 1995 and February 2, 1996.)

6.Study to Identify and Quantify Utilization Differences Attributable to The Alameda County Medical Center GME Program, Carlson Price Fass & Co., Inc., January 1996.

7.The Governor's Budget for fiscal-year 1996-97 calls for a 20 percent reduction in distinct-part/skilled-nursing facility rates for Medi-Cal. This could have a major impact on Fairmont.

8.As will be shown below, Highland's dependence on Medi-Cal beneficiaries in the mandatory aid categories has dropped significantly between 1992 and 1995. Thus, ACMC will be required to enroll fewer beneficiaries than suggested by the data in Table 14, as discussed below.

9.Memorandum to local initiatives from Joseph A. Kelly, Chief, Medi-Cal Managed Care Division, California Department of Health Services, April 27, 1995.

10.See, for example, Frederick C. Lee, "Disease Management in the Treatment of Cancer'" Medical Interface (December 1995), 126-131.

11.Quoted in Studs Terkel, Coming of Age: The Story of Our Century by Those Who've Lived It, New York: The New Press, 1995.

12.California Medical Assistance Commission, Update to the Annual Report to the Legislature, Sacramento, May, 1995, p. 9.

13.It should be noted that the actual costs of the CMSP program could be greater, since this data source is the billing system. Since ACMC does not get reimbursed for these patients it is likely that bills are not produced for all CMSP patients.

TABLES

TABLE 1

HIGHLAND: INPATIENT TRAUMA GROSS REVENUE, DISCHARGES, AND PATIENT DAYS BY SERVICE

Service	Disch	GROSS REV	LOS	PD	ADC	GR/DISCH	GR/PD
Med	26	$426,521	3.77	98.02	0.27	$16,405	$4,351
neurology	8	$107,608	2.50	20.00	0.05	$13,451	$5,380
neurosurg	51	$2,221,720	8.67	442.17	1.21	$43,563	$5,025
ob	6	$53,029	2.00	12.00	0.03	$8,838	$4,419
ophth	3	$74,313	4.67	14.01	0.04	$24,771	$5,304
oral surg	3	$103,002	5.33	15.99	0.04	$34,334	$6,442
ortho	92	$3,279,360	9.24	850.08	2.33	$35,645	$3,858
surg	3	$71,636	4.67	14.01	0.04	$23,879	$5,113
trauma	772	$17,756,449	3.80	2933.60	8.04	$23,001	$6,053
uro	1	$16,931	6.00	6.00	0.02	$16,931	$2,822
tot	965	$24,110,569	4.57	4405.88	12.07	$24,985	$5,472

HIGHLAND: INPATIENT EMERGENCY GROSS REVENUE, DISCHARGES, AND PATIENT DAYS BY SERVICE

Service	Disch	GROSS REV	LOS	PD	ADC	GR/DISCH	GR/PD
ENT	42	$283,955	3.26	136.92	0.38	$6,761	$2,074
GYN	208	$1,356,022	2.63	547.04	1.50	$6,519	$2,479
JOHN GEO PAV	30	$60,152	14.77	443.10	1.21	$2,005	$136
MEDICINE	3886	$38,057,059	4.45	17292.70	47.38	$9,793	$2,201
NEUROLOGY	325	$3,694,396	5.97	1940.25	5.32	$11,367	$1,904
NURSERY	27	$152,524	4.30	116.10	0.32	$5,649	$1,314
NEUROSURG	80	$2,577,475	8.16	652.80	1.79	$32,218	$3,948
OBSTETRICS	1794	$11,539,984	2.30	4126.20	11.30	$6,433	$2,797
OPHTHALMOL	13	$158,648	3.85	50.05	0.14	$12,204	$3,170
ORAL SURG	107	$1,388,060	3.27	349.89	0.96	$12,973	$3,967
ORTHO	397	$4,344,768	4.38	1738.86	4.76	$10,944	$2,499
PSYCH	5	$9,870	17.80	89.00	0.24	$1,974	$111
SURGERY	586	$11,501,656	6.79	3978.94	10.90	$19,627	$2,891
UROLOGY	55	$506,855	4.29	235.95	0.65	$9,216	$2,148
TOTAL	7555	$75,631,424	4.20	31697.80	86.84	$10,011	$2,386

TABLE 3

HIGHLAND: INPATIENT TRAUMA GROSS REVENUE, DISCHARGES, PATIENT DAYS AND ESTIMATED COSTS BY PAYOR

Payer	Disch	GROSS REV	LOS	PD	ADC	GR/DISCH	GR/PD	COST/DISCH	COST/PD
Bad Debt	94	$2,000,253	3.67	344.76	0.94	$21,279	$5,802	$14,576	$3,974
Blue Cross	5	$121,565	3.40	17.00	0.05	$24,313	$7,151	$16,654	$4,898
Champus	4	$64,454	2.00	8.00	0.02	$16,114	$8,057	$11,038	$5,519
CMSP	191	$4,186,830	4.37	834.67	2.29	$21,921	$5,016	$15,016	$3,436
Insurance	75	$1,888,338	4.09	306.75	0.84	$25,178	$6,156	$17,247	$4,217
Jail	21	$491,122	4.28	89.95	0.25	$23,387	$5,460	$16,020	$3,740
Kaiser	90	$2,082,262	2.53	227.70	0.62	$23,136	$9,145	$15,848	$6,264
M/Cal	257	$8,280,074	6.71	1725.44	4.73	$32,218	$4,799	$22,069	$3,287
Medicare	103	$2,398,087	4.33	445.99	1.22	$23,282	$5,377	$15,948	$3,683
Medicare B	5	$130,072	6.80	34.00	0.09	$26,014	$3,826	$17,820	$2,621
Personal Inj	42	$995,305	3.67	154.14	0.42	$23,698	$6,457	$16,233	$4,423
Self Pay	55	$877,167	2.41	132.76	0.36	$15,948	$6,607	$10,925	$4,526
Victim	23	$595,042	3.74	86.02	0.24	$25,871	$6,917	$17,722	$4,738
TOTAL	965	$24,110,571	4.57	4407.18	12.07	$24,985	$5,471	$17,115	$3,747

TABLE 4

HIGHLAND: EMERGENCY OUTPATIENT AND INPATIENT VOLUME, GROSS REVENUE AND ESTIMATED COSTS BY PAYOR

Payor	Outpatients	OP GR	DISCH	IP GR	PD	LOS	ADC	GR/DISCH	GR/PD	COST/DISCH	COST/PD	TOT GR
Bad Debt	6208	$3,230,175	408	$4,317,021	1755 60	4.30	4.81	$10,581	$2,459	$7,248	$1,684	$7,547,196
Blue Cross	39	$28,069	5	$32,318	10.00	2.00	0.03	$6,464	$3,232	$4,428	$2,214	$60,387
Champus	9	$5,419	10	$233,799	157.00	15.70	0.43	$23,380	$1,489	$16,015	$1,020	$239,218
CMSP	10762	$5,021,397	1486	$12,165,036	5221.76	3.51	14.31	$8,186	$2,330	$5,608	$1,596	$17,186,433
Insurance	217	$129,339	50	$493,801	144 00	2.88	0.39	$9,876	$3,429	$6,765	$2,349	$623,140
Jail	1734	$824,407	107	$917,979	407.82	3 81	1.12	$8,579	$2,251	$5,877	$1,542	$1,742,386
Kaiser	290	$246,745	36	$291,192	51.84	1.44	0.14	$8,089	$5,617	$5,541	$3,848	$537,937
M/Cal	12604	$6,462,597	4365	$44,895,659	18395 62	4.21	50.40	$10,285	$2,441	$7,045	$1,672	$51,358,256
Medicare	1724	$859,848	705	$9,047,304	3666 00	5.20	10.04	$12,833	$2,468	$8,791	$1,691	$9,907,152
Medicare B	2	$620	147	$1,544,938	717.36	4.88	1.97	$10,510	$2,154	$7,199	$1,475	$1,545,558
Mental	30	$20,299	37	$70,701	532 06	14.38	1.46	$1,911	$133	$1,309	$91	$91,000
Othr Dept	7	$2,698	1	$674	1.00	1 00	0 00	$674	$674	$462	$462	$3,372
Persona Inj	218	$111,283	19	$197,852	72 01	3.79	0.20	$10,413	$2,748	$7,133	$1,882	$309,135
Rx	1	$833	0									$833
Self Pay	3825	$1,382,774	173	$1,393,950	543.32	3.14	1.49	$8,058	$2,566	$5,519	$1,757	$2,776,724
Victim	22	$12,739	6	$29,202	10 02	1.67	0 03	$4,867	$2,914	$3,334	$1,996	$41,941
TOTAL	37692	$18,339,242	7555	$75,631,426	31685.41	4.19	86.81	$10,011	$2,387	$6,857	$1,635	$93,970,668

TABLE 5

HIGHLAND: TOTAL VERSUS TRAUMA AND EMERGENCY GROSS REVENUE AND VOLUME BY PAYOR

PAYOR	TOTAL OUTPATIENTS	TOTAL OP GR	TOTAL IP GR	TOTAL TOTAL GR	TRAUMA GR	ER GR	TRAUMA % TOT	ER % TOT	TOT ADC	TR ADC	ER ADC
Bad Debt	15064	$10,526,936	$8,171,499	$18,698,435	$4,262,263	$7,547,196	22.79%	40.36%	7.52	0.94	4.81
Blue Cross	92	$101,939	$163,037	$264,976	$169,767	$60,387	64.07%	22.79%	0.09	0.05	0.03
Champus	22	$26,291	$298,253	$324,544	$77,661	$239,218	23.93%	73.71%	0.45	0.02	0.43
CMSP	30513	$30,087,447	$23,459,797	$53,547,244	$5,076,098	$17,186,433	9.48%	32.10%	21.93	2.29	14.31
Insurance	690	$495,986	$2,619,074	$3,115,060	$2,062,804	$623,140	66.22%	20.00%	1.43	0.84	0.39
Jail	2106	$1,201,311	$1,963,067	$3,164,378	$654,844	$1,742,386	20.69%	55.06%	1.81	0.25	1.12
Kaiser	405	$824,240	$2,403,661	$3,227,901	$2,652,614	$537,937	82.18%	16.67%	0.78	0.62	0.14
M/Cal	31414	$31,770,217	$74,976,851	$106,747,068	$9,528,585	$51,358,256	8.93%	48.11%	85.50	4.73	50.40
Medicare	5025	$6,196,617	$13,473,225	$19,669,842	$2,398,087	$9,907,152	12.19%	50.37%	13.28	1.22	10.04
Medicare B	5	$809	$2,098,387	$2,099,196	$413,553	$1,545,558	19.70%	73.63%	2.52	0.09	1.97
Mental	10119	$217,641	$2,103,023	$2,320,664	$8,150	$91,000	0.35%	3.92%	83.69		1.46
Othr Dept	154	$547,151	$1,523	$548,674	$0	$3,372	0.00%	0.61%	0.01		0.00
Personal Inj	363	$450,275	$1,295,151	$1,745,426	$1,171,695	$309,135	67.13%	17.71%	0.65	0.42	0.20
Rx	66	$25,199	$0	$25,199	$0	$833	0.00%	3.31%			0.00
Self Pay	11669	$4,536,232	$2,528,087	$7,064,319	$1,688,095	$2,776,724	23.90%	39.31%	2.23	0.36	1.49
Victim	60	$72,126	$670,880	$743,006	$621,917	$41,941	83.70%	5.64%	0.30	0.24	0.03
TOTAL	107767	$87,080,417	$136,225,515	$223,305,932	$30,777,983	$93,970,668	13.78%	42.08%	222.19	12.07	86.81

TABLE 6

HIGHLAND AND FAIRMONT: CMSP VOLUME, GROSS REVENUE AND ESTIMATED COSTS

CMSP PATIENTS -- HIGHLAND

OP PATS	OP GR	OP GR/PAT	IP DISCH	IP GR	LOS	PD	ADC	GR/DISCH	GR/PD	COST/ DISCH	COST/PD
30513	$30,087,447	$986	2257	$23,459,797	3.55	8012.35	21.95	$10,394	$2,928	$7,130	$2,009

TOT GR
$53,547,244

CMSP PATIENTS -- FAIRMONT

OP PATS	OP GR	OP GR/PAT	IP DISCH	IP GR	LOS	PD	ADC	GR/DISCH	GR/PD	COST/ DISCH	COST/PD
10044	$7,219,531	$719	95	$976,741	9.77	928.15	2.54	$10,281	$1,052	$7,238	$741

TOT GR
$8,196,272

CMSP PATIENTS -- BOTH CAMPUSES

OP PATS	OP GR	OP GR/PAT	IP DISCH	IP GR	LOS	PD	ADC	GR/DISCH	GR/PD	COST/ DISCH	COST/PD
40557	$37,306,978	$920	2352	$24,436,538	3.80	8940.5	24.49	$10,390	$2,733	$7,135	$1,877

TOT GR
$61,743,516

TABLE 7

HIGHLAND: TOTAL VERSUS EMERGENCY, TRAUMA AND CMSP INPATIENT GROSS REVENUE AND VOLUME BY SERVICE

Service	TOTAL Disch	TOTAL GR	TOTAL ADC	ER Disch	ER GR	ER ADC	TRAUMA Disch	TRAUMA GR	TRAUMA ADC	CMSP Disch	CMSP GR	CMSP ADC
ENT	73	$870,893	0.96	42	$283,955	0.38				30	$238,200	0.27
GYN	449	$4,650,888	4.06	208	$1,356,022	1.50				125	$1,511,948	1.22
JOHN GEO PAV	2559	$2,032,515	81.47	30	$60,152	1.21				1	$521	0.02
MEDICINE	4421	$44,385,631	56.20	3886	$38,057,059	47.38	26	$426,521	0.27	920	$5,725,721	7.76
NEWBORN	1	$6,700	0.01									
NEUROLOGY	403	$5,316,888	7.55	325	$3,694,396	5.32	8	$107,608	0.05	68	$559,556	0.64
NURSERY	1668	$5,752,892	14.12	27	$152,524	0.32	51	$2,221,720	1.21	1	$1,146	0.01
NEUROSURG	179	$6,806,049	4.21	80	$2,577,475	1.79				34	$624,831	0.39
OBSTETRICS	1860	$11,994,032	11.77	1794	$11,539,984	11.30	6	$53,029	0.03	6	$54,100	0.04
OPHTHALMOL	19	$257,381	0.21	13	$158,648	0.14	3	$74,313	0.04	6	$94,851	0.08
ORAL SURG	215	$3,316,133	1.66	107	$1,388,060	0.96	3	$103,002	0.04	113	$1,751,171	0.95
ORTHO	776	$11,695,938	10.12	397	$4,344,768	4.76	92	$3,279,360	2.33	321	$3,638,261	3.21
PSYCH	101	$70,189	2.26	5	$9,870	0.24						
SURGERY	1029	$19,993,717	18.13	586	$11,501,656	10.90	3	$71,636	0.04	427	$5,647,881	5.22
TRAUMA	774	$18,050,212	8.21				772	$17,756,449	8.04	162	$3,227,146	1.71
UROLOGY	96	$1,025,456	1.11	55	$506,855	0.65	1	$16,931	0.02	43	$384,466	0.41
TOTAL	14623	$136,225,514	222.04	7555	$75,631,424	86.84	965	$24,110,569	12.07	2257	$23,459,799	21.91
EXCL JOHN GEO AND NUR DISCH	10396	$134,192,999	126.45	7498	$75,571,272	85.31	914	$24,110,569	10.86	2255	$23,459,278	21.89

HIGHLAND: CALCULATION OF TRAUMA PLUS CMSP AND EMERGENCY PLUS CMSP

CMSP GROSS REV	$53,547,244
CMSP ADC	21.95
NON CMSP TRAUMA	
GR	$25,701,885
ADC	9.79
NON CMSP EMERGENCY	
GR	$76,784,235
ADC	72.50
TR AUMA PLUS CMSP	
GR	$79,249,129
ADC	31.74
EMERGENCY PLUS CMSP	
GR	$130,331,479
ADC	94.45

TABLE 9

HIGHLAND: CMSP INPATIENT GROSS REVENUE AND VOLUME BY SERVICE

Service	Disch	GR	LOS	PD	ADC	GR/DISCH	GR/PD
ENT	30	$238,200	3.27	98.10	0.27	$7,940	$2,428
GYN	125	$1,511,948	3.55	443.75	1.22	$12,096	$3,407
JOHN GEO PAV	1	$521	6.00	6.00	0.02	$521	$87
MEDICINE	920	$5,725,721	3.08	2833.60	7.76	$6,224	$2,021
NEUROLOGY	68	$559,556	3.41	231.88	0.64	$8,229	$2,413
NURSERY	1	$1,146	2.00	2.00	0.01	$1,146	$573
NEUROSURG	34	$624,831	4.15	141.10	0.39	$18,377	$4,428
OBSTETRICS	6	$54,100	2.67	16.02	0.04	$9,017	$3,377
OPHTHALMOL	6	$94,851	4.67	28.02	0.08	$15,809	$3,385
ORAL SURG	113	$1,751,171	3.07	346.91	0.95	$15,497	$5,048
ORTHO	321	$3,638,261	3.65	1171.65	3.21	$11,334	$3,105
SURGERY	427	$5,647,881	4.46	1904.42	5.22	$13,227	$2,966
TRAUMA	162	$3,227,146	3.86	625.32	1.71	$19,921	$5,161
UROLOGY	43	$384,466	3.47	149.21	0.41	$8,941	$2,577
TOTAL	2257	$23,459,799	3.54	7997.98	21.91	$10,394	$2,933

HIGHLAND: TOTAL INPATIENT GROSS REVENUE, DISCHARGES, PATIENT DAYS AND ESTIMATED COSTS BY PAYOR

PAYER	DISCH	GR	LOS	PD	ADC	GR/DISCH	GR/PD	COST/DISCH	COST/PD
Bad Debt	621	$8,171,499	4.42	2743.50	7.52	$13,159	$2,978	$9,014	$2,040
Blue Cross	12	$163,037	2.75	33.00	0.09	$13,586	$4,941	$9,307	$3,384
Champus	14	$298,253	11.79	165.06	0.45	$21,304	$1,807	$14,593	$1,238
CMSP	2257	$23,459,797	3.55	8005.00	21.93	$10,394	$2,931	$7,120	$2,007
Insurance	139	$2,619,074	3.75	521.25	1.43	$18,842	$5,025	$12,907	$3,442
Jail	177	$1,963,067	3.73	659.44	1.81	$11,091	$2,977	$7,597	$2,039
Kaiser	129	$2,403,661	2.20	283.80	0.78	$18,633	$8,470	$12,764	$5,802
M/Cal	7157	$74,976,851	4.36	31209.32	85.50	$10,476	$2,402	$7,176	$1,646
Medicare	911	$13,473,225	5.32	4846.52	13.28	$14,789	$2,780	$10,131	$1,904
Medicare B	172	$2,098,387	5.35	920.20	2.52	$12,200	$2,280	$8,357	$1,562
Mental	2661	$2,103,023	11.48	30548.28	83.69	$790	$69	$541	$47
Othr Dept	2	$1,523	1.00	2.00	0.01	$762	$762	$522	$522
Personal Inj	69	$1,295,151	3.46	238.74	0.65	$18,770	$5,425	$12,858	$3,716
Rx	0	$0							
Self Pay	270	$2,528,087	3.02	815.68	2.23	$9,363	$3,099	$6,414	$2,123
Victim	32	$670,880	3.41	109.12	0.30	$20,965	$6,148	$14,361	$4,211
TOTAL	14623	$136,225,515	5.55	81100.91	222.19	$9,316	$1,680	$6,381	$1,151

TABLE 11

HIGHLAND: TOTAL VERSUS MEDI-CAL INPATIENT GROSS REVENUE DISCHARGES AND ADC BY SERVICE

Service	TOTAL Disch	TOTAL GR	TOTAL ADC	MEDI-CAL DISCH	MEDI-CAL GR	MEDI-CAL LOS	MEDI-CAL PD	MEDI-CAL ADC	MEDI-CAL %	MEDI-CAL COST PD
ENT	73	$870,893	0.96	29	$524,735	7.14	207.06	0.57	58.97%	$1,736
GYN	449	$4,650,888	4.06	276	$2,633,402	3.26	899.76	2.47	60.72%	$2,005
JOHN GEO PAV	2559	$2,032,515	81.47	1	$234	8.00	8.00	0.02	0.03%	$20
MEDICINE	4421	$44,385,631	56.20	2218	$25,143,231	5.35	11866.30	32.51	57.85%	$1,451
NEWBORN	1	$6,700	0.01	1	$6,700	4.00	4.00	0.01	100.00%	$1,147
NEUROLOGY	403	$5,316,888	7.55	223	$3,436,837	8.26	1841.98	5.05	66.82%	$1,278
NURSERY	1668	$5,752,892	14.12	1613	$5,594,841	3.09	4984.17	13.66	96.70%	$769
NEUROSURG	179	$6,806,049	4.21	75	$3,656,133	10.61	795.75	2.18	51.81%	$3,147
OBSTETRICS	1860	$11,994,032	11.77	1771	$11,453,771	2.33	4126.43	11.31	96.04%	$1,901
OPHTHALMOL	19	$257,381	0.21	5	$73,439	4.00	20.00	0.05	25.99%	$2,515
ORAL SURG	215	$3,316,133	1.66	54	$788,810	2.46	132.84	0.36	21.91%	$4,068
ORTHO	776	$11,695,938	10.12	259	$4,961,983	6.63	1717.17	4.70	46.49%	$1,979
PSYCH	101	$70,189	2.26							
SURGERY	1029	$19,993,717	18.13	408	$10,334,719	8.24	3361.92	9.21	50.81%	$2,106
TRAUMA	774	$18,050,212	8.21	199	$6,077,850	5.49	1092.51	2.99	36.47%	$3,811
UROLOGY	96	$1,025,456	1.11	25	$290,166	4.88	122.00	0.33	30.19%	$1,629
TOTAL	14623	$136,225,514	222.04	7157	$74,976,851	4.36	31179.89	85.42	38.47%	$1,647
EXCL JOHN GEO AND NUR DISCH	10396	$134,192,999	126.45	5543	$74,976,617	4.72	26187.72	71.75	56.74%	$1,961

HIGHLAND: TOTAL INPATIENT GROSS REVENUE, DISCHARGES, ADC AND ESTIMATED COSTS BY SERVICE

Service	Disch	GR	LOS	PD	ADC	GR/DISCH	GR/PD	COST/DISCH	COST/PD
ENT	73	$870,893	4.81	351.13	0.96	$11,930	$2,480	$8,172	$1,699
GYN	449	$4,650,888	3.30	1481.70	4.06	$10,358	$3,139	$7,095	$2,150
JOHN GEO PAV	2559	$2,032,515	11.62	29735.58	81.47	$794	$68	$544	$47
MEDICINE	4421	$44,385,631	4.64	20513.44	56.20	$10,040	$2,164	$6,877	$1,482
NEWBORN	1	$6,700	4.00	4.00	0.01	$6,700	$1,675	$4,590	$1,147
NEUROLOGY	403	$5,316,888	6.84	2756.52	7.55	$13,193	$1,929	$9,037	$1,321
NURSERY	1668	$5,752,892	3.09	5154.12	14.12	$3,449	$1,116	$2,363	$765
NEUROSURG	179	$6,806,049	8.58	1535.82	4.21	$38,023	$4,432	$26,045	$3,036
OBSTETRICS	1860	$11,994,032	2.31	4296.60	11.77	$6,448	$2,792	$4,417	$1,912
OPHTHALMOL	19	$257,381	4.05	76.95	0.21	$13,546	$3,345	$9,279	$2,291
ORAL SURG	215	$3,316,133	2.82	606.30	1.66	$15,424	$5,469	$10,565	$3,747
ORTHO	776	$11,695,938	4.76	3693.76	10.12	$15,072	$3,166	$10,324	$2,169
PSYCH	101	$70,189	8.15	823.15	2.26	$695	$85	$476	$58
SURGERY	1029	$19,993,717	6.43	6616.47	18.13	$19,430	$3,022	$13,310	$2,070
TRAUMA	774	$18,050,212	3.87	2995.38	8.21	$23,321	$6,026	$15,975	$4,128
UROLOGY	96	$1,025,456	4.21	404.16	1.11	$10,682	$2,537	$7,317	$1,738
TOTAL	14623	$136,225,514	5.54	81045.08	222.04	$9,316	$1,681	$6,381	$1,151
EXCL JOHN GEO AND NUR DISCH	10396	$134,192,999	4.44	46155.38	126.45	$12,908	$2,907	$8,842	$1,992

TABLE 13

ALAMEDA COUNTY HOSPITALS: OCCUPANCY, EXPENSES, NET REVENUE AND INDIGENT PAYOR MIX -- FY 1995

HOSPITAL	AVL-BEDS	TOT-PD	MCL-PD	CNTY-IND-PD	LT-PD	OCC-AVL	TOT-LOS	MCL-LOS	CNTY-IND-LOS
ALAMEDA CO MED CTR - FAIRMONT CAMPUS	293	69459	58331	1291	0	64.95	49.68	58.27	8.66
ALAMEDA CO MED CTR - HIGHLAND CAMPUS	274	76807	42211	7619	0	76.80	5.99	6.13	3.46
ALAMEDA HOSPITAL	145	21838	1712	105	5848	41.26	5.65	3.53	3.18
ALTA BATES MEDICAL CENTER	458	121686	27865	55	20264	71.61	6.33	8.91	3.93
C P C. FREMONT HOSPITAL	78	16333	614	0	0	57.37	9.72	4.99	
CHILDREN'S HOSPITAL MED CTR OF NO CA	193	55168	37326	15	0	78.31	6.28	6.53	2.50
EDEN MEDICAL CENTER	244	42377	2859	708	12511	47.58	5.14	10.67	3.36
LAUREL GROVE HOSPITAL	61	10585	0	0	3307	47.54	17.38		
MERRITT PERALTA INSTITUTE C.D.R.H.	48	4244	0	0	0	24.22	10.43		
SAN LEANDRO HOSPITAL	136	22866	341	0	0	46.06	4.65	3.19	
ST. ROSE HOSPITAL	175	34184	11028	259	0	53.52	5.35	4.29	2.76
SUMMIT MEDICAL CENTER	358	95425	19183	0	15217	73.03	5.19	3.78	
THUNDER ROAD CHEMICAL DEPENDENCY	50	16262	0	9810	0	89.11	68.62		115.41
VALLEY MEMORIAL HOSPITAL	161	25539	1325	83	0	43.46	4.24	2.76	4.15
VENCOR HOSPITAL - SAN LEANDRO	56	13722	147	0	0	67.13	45.29	24.50	
WASHINGTON HOSPITAL - FREMONT	213	48002	9316	28	0	61.74	4.16	4.41	2.55
TOTAL	2943	674497	212258	19973	57147	62.79			

HOSPITAL	TOT-NR INCL-SB855	TOT-NR	MCL-NR-INCL SB855	MCL-NR	CNTY-IND-NR	TOT-EXP	MCL-EXP	CNTY-IND-EXP	MCL-EXP %	MCL-PD %	CNTY-IND-PD %
ALAMEDA CO MED CTR - FAIRMONT CAMPUS	$47,493,651	$42,134,466	$34,846,603	$29,487,418	$5,360,089	$46,445,041	$31,153,741	$6,251,011	9.13%	27.48%	6.46%
ALAMEDA CO MED CTR - HIGHLAND CAMPUS	$182,435,078	$118,875,559	$109,701,035	$46,141,516	$30,326,964	$160,450,304	$76,982,406	$31,660,050	22.57%	19.89%	38.15%
ALAMEDA HOSPITAL	$33,763,405	$33,763,405	$1,435,024	$1,435,024	$169,336	$33,894,702	$2,693,203	$96,605	0.79%	0.81%	0.53%
ALTA BATES MEDICAL CENTER	$264,410,904	$264,410,904	$33,890,653	$33,890,653	$127,140	$270,327,437	$59,382,697	$135,987	17.41%	13.13%	0.28%
C P C. FREMONT HOSPITAL	$8,409,295	$8,409,295	$166,724	$166,724	$0	$7,216,859	$288,031	$0	0.08%	0.29%	0.00%
CHILDREN'S HOSPITAL MED CTR OF NO CA	$136,020,247	$121,124,347	$89,786,890	$74,890,990	$36,121	$147,147,099	$93,969,072	$272,093	27.55%	17.59%	0.08%
EDEN MEDICAL CENTER	$72,582,793	$72,582,793	$2,720,536	$2,720,536	$2,037,985	$67,544,127	$4,993,712	$1,599,758	1.46%	1.35%	3.54%
LAUREL GROVE HOSPITAL	$9,595,326	$9,595,326	$427,516	$427,516	$0	$9,917,229	$30,675	$0	0.01%	0.00%	0.00%
MERRITT PERALTA INSTITUTE C.D.R.H.	$1,557,781	$1,557,781	$0	$0	$0	$1,401,689	$0	$0	0.00%	0.00%	0.00%
SAN LEANDRO HOSPITAL	$42,195,305	$42,195,305	$582,083	$582,083	$0	$39,222,562	$976,463	$0	0.29%	0.16%	0.00%
ST. ROSE HOSPITAL	$46,655,318	$46,655,318	$9,672,001	$9,672,001	$0	$45,971,585	$15,484,495	$361,548	4.54%	5.20%	1.30%
SUMMIT MEDICAL CENTER	$171,567,685	$168,084,685	$22,132,808	$18,649,808	$0	$171,550,320	$33,908,221	$0	9.94%	9.04%	0.00%
THUNDER ROAD CHEMICAL DEPENDENCY	$2,918,937	$2,918,937	$0	$0	$1,660,775	$3,204,449	$0	$1,558,514	0.00%	0.00%	49.12%
VALLEY MEMORIAL HOSPITAL	$65,253,513	$65,253,513	$1,815,795	$1,815,795	$0	$68,129,020	$3,611,085	$197,575	1.06%	0.62%	0.42%
VENCOR HOSPITAL - SAN LEANDRO	$14,309,876	$14,309,876	$33,649	$33,649	$0	$12,446,261	$122,154	$0	0.04%	0.07%	0.00%
WASHINGTON HOSPITAL - FREMONT	$115,235,939	$115,235,939	$3,730,509	$3,730,509	$42,214	$104,948,920	$17,521,212	$39,153	5.14%	4.39%	0.14%
TOTAL	$1,214,405,053	$1,127,107,449	$310,941,826	$223,644,222	$39,760,624	$1,189,817,604	$341,117,167	$42,172,292	100.00%	100.00%	100.00%

SOURCE: OSHPD QUARTERLY REPORTS, 12-MONTH PERIOD ENDING JUNE 30, 1995

TABLE 14

TOTAL AND MANDATORY MEDI-CAL PATIENT DAYS AND ENROLLEE EQUIVALENTS: MAJOR HOSPITALS ALAMEDA COUNTY

HOSPITAL	PAT DAYS NON-CROSS-OVR	PAT DAYS CROSS-OVR	PAT DAYS MANDATORY	PAT DAYS MANDATORY CCS	PAT DAYS TOTAL CCS	PAT DAYS NET MANDATORY	NET MAND % NON-CROSS-OVR	ENROLLEE EQUIVALENTS AT COUNTY UTIL RATE	ADULT EQUIVALENTS AT COUNTY UTIL RATE
HIGHLAND GEN HOSPITAL	28736	3103	8320	1	3	8319	28.95%	31,358	18,821
CHILDRENS HOSP MED CTR	24454	0	18601	9916	14464	8685	35.52%	32,738	
FAIRMONT HOSPITAL	21517	2405	1229	0	8	1229	5.71%	4,633	2,781
ALTA BATES HOSPITAL	20960	9564	9016	1352	2094	7664	36.56%	28,889	
SAMUEL MERRITT HOSPITAL	15293	0	6419	0	66	6419	41.97%	24,196	
WASHINGTON HOSPITAL	7981	4427	1838	0	0	1838	23.03%	6,928	
ST ROSE HOSPITAL	7813	0	2789	0	0	2789	35.70%	10,513	
EAST BAY HOSPITAL	5230	1279	381	0	0	381	7.28%	1,436	
U C SAN FRANCISCO HOSP	2674	0	1073	476	777	597	22.33%	2,250	
PROVIDENCE HOSPITAL	2604	2249	312	0	2	312	11.98%	1,176	
ALAMEDA HOSPITAL	2074	1999	297	0	0	297	14.32%	1,120	
EDEN HOSPITAL	1620	3241	313	0	0	313	19.32%	1,180	
STANFORD UNIVERSITY HOSP	1391	470	479	53	74	426	30.63%	1,606	
LUCILE SALTER PACKARD	1364	0	803	499	992	304	22.29%	1,146	
ST MARYS HOSP & MED CTR	1358	0	876	50	50	826	60.91%	3,114	
TOTAL > 1,000 PAT DAYS NXVR	145067	28737	52746	12347	18530	40399	27.85%	152,282	
ALL OTHER HOSPITALS	13331	23264	4910	475	841	4435	33.27%	16,718	
TOTAL	158398	52001	57656	12822	19371	44834	28.30%	169,000	
MAND PAT DAYS/1,000 BENES						*265.29*			
MAND ADULT PAT DAYS/1,000 ADULTS						*442*			

TABLE 15

HIGHLAND: TOTAL MEDI-CAL AND MANDATORY PATIENT DAYS BY SERVICE

SERVICE	TOT PAT DAYS	MAND PAT DAYS	%
ICU	4670	562	12.03%
MED/SUR/GYN	16112	2498	15.50%
NICU	1313	875	66.64%
NURSERY	462	262	56.71%
OB	4125	1736	42.08%
OTHER ACUTE	1142	0	0.00%
TOTAL	27824	5933	21.32%

TABLE 16

ESTIMATED IMPACT ON PRIVATE HOSPITALS OF CMSP CONTRACTING

HIGHLAND AND FAIRMONT

TOTAL CMSP GROSS REV	$61,743,516
ESTIMATED COST	$42,400,475
REALIGNMENT REVENUE	$24,770,000
SHORTFALL	$17,630,475

HIGHLAND

MEDI-CAL GROSS REV INPAT	$74,976,851
MEDI-CAL GROSS REV OUTPAT	$31,770,217
MEDI-CAL TOTAL GROSS REV	$106,747,068
MEDI-CAL ESTIMATED COST	$73,121,742
ESTIMATED NET REV	$43,827,521
NET REV % OF COST	59.94%